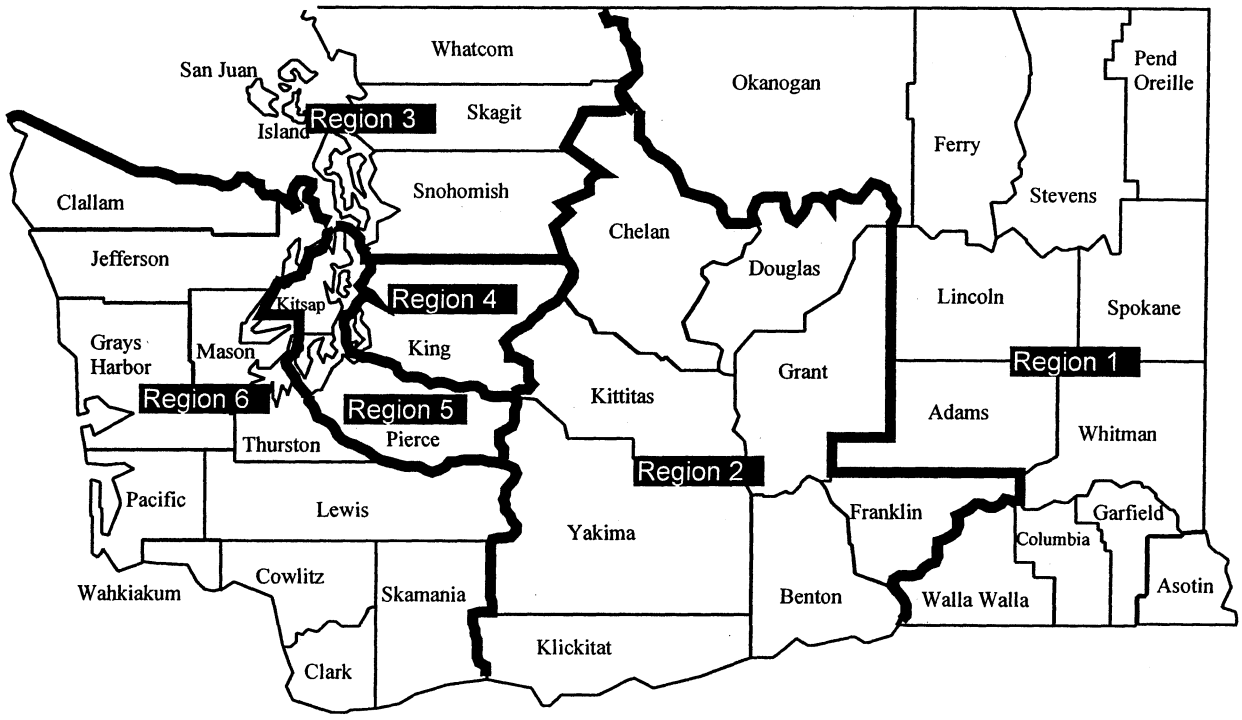
WASHINGTON STATE HIV PREVENTION PLAN



2002-2003

WASHINGTON STATE HIV PREVENTION PLAN

CONTENTS OF PLAN

LIST OF TABLES

LIST OF FIGURES

PURPOSE OF THE 2002-2003 WASHINGTON STATE HIV PREVENTION PLAN

The 2002-2003 Washington State Prevention Plan is a compilation of the six regional HIV plans and the planning provided by the Washington State HIV Prevention Planning Group. This plan provides the following:

1. Priorities and recommendations for HIV prevention throughout the state;
2. An overview of the planning process and HIV prevention efforts in the state;
3. A report to the community on the efforts of the many people involved in the planning process on a statewide basis;
4. A document to support the linkage and collaborations necessary to assure funding, services and other prevention efforts throughout the state; and
5. Meeting the requirements for community planning under the cooperative agreement with the Centers for Disease Control and Prevention (CDC) for federal prevention funding in the state.

INTRODUCTION

HIV has touched the lives of almost everyone living on the planet. No other public health issue has had such a far reaching and devastating impact on the social, economic, medical or spiritual lives of so many. In developing countries, HIV is clearly a sexually transmitted disease striking men, women and their children with painful loss. In the United States, HIV found its way into groups of people who practiced behaviors that put them at high risk for transmitting the virus; men who had unprotected anal sex with other men and people who used intravenous drugs. There was an epidemic of heroin addiction and intravenous drug use (IDU) with many patterns of needle sharing. The resulting transmission of HIV was, therefore, seen primarily in gay men and IV drug users and the early cases were, therefore, associated primarily with these behaviors. Therefore, people thought that AIDS was limited to these "risk groups."

Much of society believed that people who were gay or used illegal drugs by injection were immoral and/or criminal. The growing numbers of sick and dying were more often attacked and shunned than supported. When the numbers grew at alarming rates and public health officials began to talk about the 'epidemic,' there was an immediate clash between the politics and the prevention of HIV. Some public officials and commentators talked about innocent victims and "those who deserved it." Public health officials tried to apply standard disease and prevention methods, only to find that those methods were often seen as an infringement of the civil rights of those involved. Instead of being handled as a health problem, HIV moved from the public health arena to the political.

By the mid-1980's, technologies had been developed to identify the HIV antibodies in the blood. Transmission of HIV through blood transfusions rapidly decreased. By the late 1980's, the other blood products (such as Factor 8 for hemophiliacs) were also being screened. With the screening of blood and blood products, about the only way that HIV was transmitted from one person to another was through sharing of needles, unprotected sexual intercourse and to unborn or nursing babies of HIV positive women.
Because most of the HIV infections were still found primarily in gay men and injecting drug users, almost any intervention suggested met with resistance from either the public or the affected community. [For example: distribution of condoms with targeted, specific messages for gay men were considered to be condoning "immoral" or "perverted" behavior lifestyles or outside of general community norms and values.] Many materials and projects could not be funded with federal prevention dollars and were, therefore, not available. An example for injecting drug users: If an HIV positive drug user shares a needle for drug use, HIV can be transmitted. Logically that means that supplying the person a clean needle would reduce the risk of HIV transmission. This concept resulted in the needle exchange programs to provide clean needles. Because many people viewed this approach as contrary to the 'war on drugs,' federal funds were restricted from this intervention. Many communities, with other available funds, have started needle exchanges, but it is still very controversial and is, still, a prohibited activity through use of federal funds.

The first case of AIDS was reported in Washington State in 1982. In 1988, the Washington State legislature established the AIDS Omnibus Act. This Act defined the HIV prevention services that the local health jurisdictions were required to provide. It also divided the state into six AIDS services regions or networks (AIDSNETs). Most of the regions established a variety of internal planning, advisory and contracting processes. With the Omnibus legislation, there was a commitment of state dollars for prevention and some care efforts.

In 1993, the CDC community planning requirements were released which formalized community planning. The Washington State HIV Prevention Planning Group (SPG) was established and community participation at the regional level expanded. For the first four years, inclusion of regional and AIDSNET representatives on the SPG, coordination of regional efforts and state planning was attempted. However, there were fundamental issues (regional and state perspectives) that kept this effort from being successful. In October 1997, in Ellensburg, WA, a retreat brought together the SPG, regional planning groups, AIDSNET directors and coordinators, and Department of Health staff to review what was working in the planning process, what needed to be changed, and how the elements could be integrated. The result of this process was a document outlining the roles and responsibilities of the four groups, known as the Ellensburg Document. (see Attachment 1)

Under the agreed roles and responsibilities from this process, the SPG establishes the procedures (guidance) for completing the planning processes. The regional planning groups (RPG) establish the priorities for the prevention efforts at the regional level. The SPG has the additional responsibility for the prioritization of the set-aside CDC resources that are used for statewide projects, activities, and interventions. Because of the wide range of timelines and processes in the regional planning process, previous state plans have included enormous quantities of text and materials.

The goal in the 2002-2003 Washington State HIV Prevention Plan is designed to capture all of this information in a single document, the Washington State HIV Prevention Plan.

Under the guidance and requirements of the CDC, the community planning process and the resulting plan must contain the following information:

The Basic Steps of the Planning Process

1. Epidemiologic (Epi) Profile

In order to assess the size and affect of the HIV epidemic in your area, an Epi Profile is developed by either the local health jurisdiction or Department of Health (DOH) assessment office. This Epi Profile will contain the important statistical and supplemental information needed to develop a portrait of the epidemic over the years and the populations at-risk in Washington State. This information will be gathered from a wide range of sources including disease reporting, surveillance, interviews, focus groups, surveys, community hearing and meetings, other related statistical information and

markers, and local, statewide and national reports. An expert in the field of epidemiology and assessment will facilitate presentation and discussion of this information.

2. Community Resource Inventory (CRI)
Each planning group will compile a resource inventory. This information may be generated through the SHARE (Statewide HIV Activity, Reporting and Evaluation) data collection system for those interventions funded through targeted CDC or Omnibus funds. For other resources, it is common for planning groups to survey the service providers. Regardless of the source of the information, the CRI should answer the question: "Who is doing what, for whom, in HIV prevention and how are those services delivered?" A final question may be: "At what cost?"

3. Gap Analysis
Each planning group must be able to clearly define the ***needs*** (needs assessment) of the at-risk populations in their region. Using the information collected about the ***resources*** available to meet their needs, the planning groups can determine those needs that are not being met. Through a decision making process, the ***unmet needs*** can be prioritized and effective interventions can be identified. Analysis of the differences between the present use of resources and the priorities may identify gaps in services. This analysis may result in a shift in resources to fill identified gaps.

4. Effective Interventions
Each planning group must determine a prioritized list of effective interventions for the at-risk populations. These interventions should be scientifically and behaviorally proven to meet the needs of the population served and result in changes that reduce the transmission of HIV. If no proven interventions are known or deemed appropriate, then unproven programs can be used if there is a strong commitment to evaluation of effectiveness. When the HIV prevention plan is written, it must cite the reasons why a particular intervention will work among the identified population.

5. Priority Setting
Using the Epi Profile and other supporting information, each planning group will set the priorities for HIV prevention in the region. The priorities and gap analysis will establish those needs and interventions that should be supported by available resources. Final funding decisions are made by DOH, with the budgets of the AIDSNETs, local health jurisdictions (LHJs), and the contractual formulae.

6. Writing the Plan
Putting it all together. Each planning group is responsible for approving the final written document, the *HIV Prevention Plan* for each region. Members of the planning group, support staff or other identified people may have written this document, but the final plan must be the product of an approval process by the entire group. Once the regional plan is complete, these region plans are compiled and a statewide plan is developed by DOH. This statewide plan is approved by the SPG. This state plan becomes the basis for submission of the CDC application.

7. Evaluation
Each year planning groups must evaluate the planning process to suggest ways to improve the process in the following year.

8. Concurrence
Each planning group must determine the degree of congruence (match) between the priorities established in the prevention plan and the allocations established by DOH or the AIDSNET/LHJ. A letter from the planning group to DOH indicating the degree of concurrence or non-concurrence is submitted with each regional HIV prevention plan.

This plan will, therefore outline and summarize all of the above steps for the six regional and the state planning groups.

For more information on CDC, community planning and/or HIV/AIDS, please call the Washington State HIV/AIDS Hotline at 1-800-272-2437 or the National HIV Hotline at 1-800-342-2437. For access on the Web, go to www.doh.gov/cfh/hiv.htm for the Washington website and www.cdc.gov/hiv/dhap.htm for CDC, Division of HIV/AIDS Prevention.

WHO

ARE

WE

WHO ARE WE

WASHINGTON STATE

Washington State is number 15 in total population and number 19 in cases of AIDS in the United States. The first case of AIDS was reported in 1982 and there are a total of 9421 cases of AIDS reported in the state, since 1982. The general demographics of Washington and the six AIDSNET regions are as follows:

TABLE 1
DEMOGRAPHICS OF WASHINGTON STATE (2000 Census Data)

DEMO-GRAPHIC	STATE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5		REGION 6
Population	5,894,121	658,381	617,258	942,527	1,737,034	941,967		956,605
Gender:								
Female	50%	50%	50%	50%	50%	50%		51%
Male	50%	50%	50%	50%	50%	50%		49%
Race/Ethn						Kit	Pier	
African Am.	3%	1%	1%	1%	5%	3%	8%	1%
Amer. Ind.	3%	2%	2%	2%	1%	5%	7%	4%
Asian/Pac	4%	2%	2%	4%	11%	4%	4%	3%
Hispanic	6%	6%	25%	4%	5%	2%	1%	2%
White	83%	88%	71%	89%	78%	86%	80%	90%
Age:								
<14	21%	22%	25%	23%	19%	22%		22%
15-19	7%	8%	7%	7%	6%	9%		7%
20-29	13%	14%	12%	12%	7%	11%		12%
30-39	16%	14%	14%	15%		14%		16%
40-49	16%	15%	15%	16%	38%	16%		16%
50-59	11%	11%	11%	12%	15%	12%		12%
60+	15%	16%	15%	15%	15%	16%		15%
		Rural	Rural	Rural/Mid	Urban	Rural/Urb		Rural/Urb

The six regions, with lead agency listed first, are:

REGION 1: *Spokane Regional Health District*: Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman.

REGION 2: *Yakima Health District*: Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat, and Yakima.

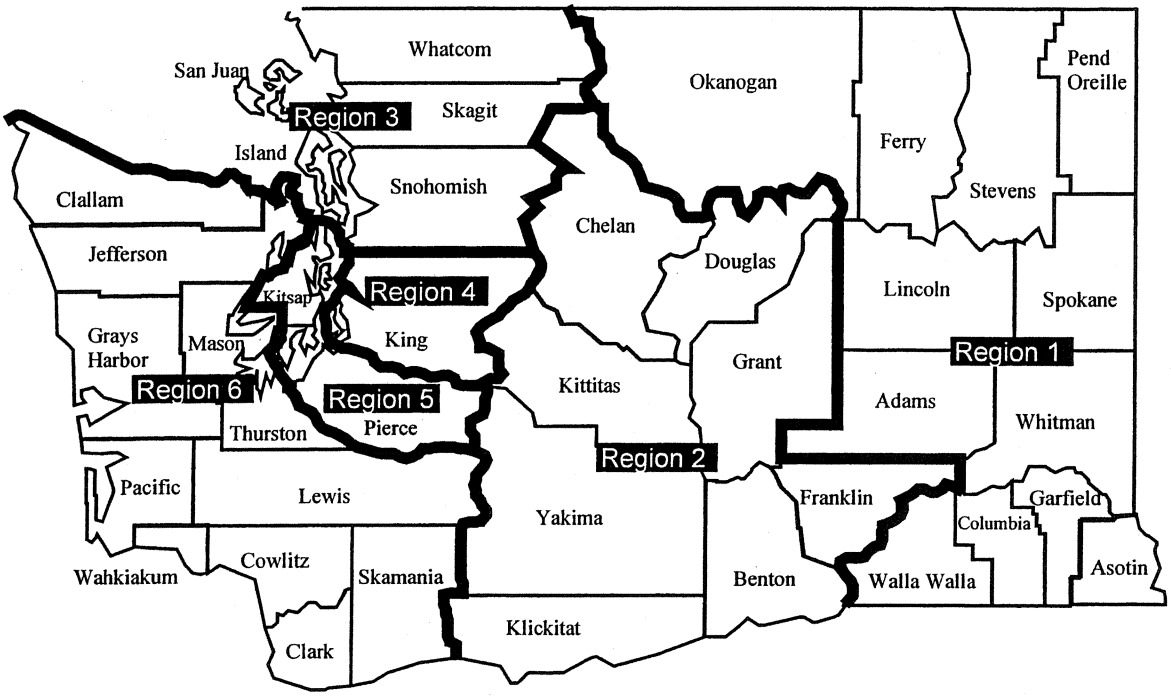
REGION 3: *Snohomish Health District*: Island, San Juan, Skagit, Snohomish, and Whatcom.

REGION 4: *Public Health-Seattle & King County*: King.

REGION 5: *Tacoma-Pierce County Health Department*: Kitsap and Pierce.

REGION 6: *Southwest Washington Health District*: Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum.

FIGURE 1: Map of AIDSNET Regions, by County



Each of the six regions has an HIV Prevention Planning group (RPG). Region 5 has two community planning groups (CPGs), Kitsap and Pierce counties, due to the great disparity between the counties and planning issues. A single plan is, however, submitted. These planning groups are responsible for developing the Regional HIV Prevention Plan. Through their efforts the demographics of HIV/AIDS in their respective areas are reviewed, needs are determined and priorities are established. Membership on the planning group is governed by the charter or by-laws. All of the RPG's have membership committees that recruit and nominate new members, provide support for active members, and review the membership. The number of members on each RPG varies with the by-law requirements and character of the region. Under guidance from CDC and the SPG, each RPG must have a Parity, Inclusion and Representation (PIR) Plan for recruiting, retaining, orienting, and training. Each RPG selects three (3) members to represent the region on the WA State HIV Prevention Planning Group (SPG). It is requested that public health, community-based organizations, and the infected/affected communities be represented by at least one member.

The state planning group (SPG) consists of 30 members (with 2 additional slots available to meet the recommendations of the PIR plan). Eighteen (18) of the members are appointed by the RPG's and twelve (12) members are nominated by the SPG

Membership Committee and appointed by the Washington State Department of Health (DOH). These 12 at-large members may be selected to provide technical knowledge, population or geographic parity (balance) or services representation. Tables 2, 3 and 4 summarize the demographics, membership representation and expertise found on each of the planning groups.

TABLE 2
MEMBER PROFILE DATA COMPARISON – AS OF 7/1/01

		State Planning Group*	Regional Planning Groups (Total)	EPI Profile – Persons Living with AIDS
GENDER	Male	70%	51%	90%
	Female	30%	47%	10%
	Transgender	0%	2%	Unknown
AGE	13-24	0%	7%	9%
	25-44	33%	45%	65%
	45-65	63%	46%	24%
	66 and over	4%	2%	2%
SEXUAL IDENTITY	Bisexual	0%	6%	Unknown
	Heterosexual	44%	45%	7%
	Homosexual	56%	39%	63%
	Transgender	0%	2%	Unknown
	Unknown	0%	8%	8%
GEOGRAPHIC LOCATION	Urban	36%	28%	
	Mid-size (<100,000)	36%	31%	
	Rural	18%	41%	
RACE/ ETHNICITY	African American	14%	12%	12%
	Caucasian	76%	73%	75%
	Hispanic/Latino	7%	9%	9%
	Asian- Pacific Islander	0%	2%	2%
	American Indian Alaskan Native	3%	4%	2%
	Other	0%	1%	Unknown
HIV STATUS	HIV+	43%	25%	
RISK EXPOSURE (of HIV+)	MSM	41%		
	IDU	17%		
	MSM/IDU	17%		
	Heterosexual	25%		
TOTAL NUMBER OF MEMBERS*		**28**	**127**	

*Eighteen (18) members of the State Planning Group are also members of a Regional Planning Group

TABLE 3
PLANNING GROUP MEMBERSHIP BY GOVERNMENTAL AND NON-GOVERNMENTAL REPRESENTATION

ORGANIZATION/COMMUNITY	Number of Members on State Planning Group	Number of Members on Regional Planning Groups
State Health Department	3	2
Local Health Department(s)	8	25
Education Agencies	1	2
Correction Agencies	1	1
Mental Health Agencies		
Substance Abuse Agencies	1	1
Youth Agencies		1
Other Governmental Agencies		3
Total Government Members	14 (50%)	35 (28%)
Community-based AIDS Service Providers	4	37
Faith Organization		2
Academic Institutions	1	2
Mental Health Organizations		5
Volunteer Organization	1	4
Youth Organization	1	6
Business Organization		
Substance Abuse Program	1	5
Other Non-governmental Organization		1
Total Non-Governmental Org. Members	8 (29%)	62 (49%)
Total Community Members (Not organizational members)	6 (21%)	30 (24%)
Total Members of Planning Group (Total of governmental+non-governmental+community members)	**28**	**127**

Table 4:
PLANNING GROUP MEMBEERS BY EDUCATIONAL OR SCIENTIFIC TRAINING

EPIDEMIOLOGY	BEHAVIORAL OR SOCIAL SCIENCE	EVALUATION RESEARCHER	INTERVENTION SPECIALIST	HEALTH PLANNER
State / Regional	State / Regional	State / Regional	State / Regional	State / Regional
5 11	10 31	5 15	3 18	4 15

Each of the groups has an appointed health department co-chair and an elected community co-chair. Several groups also have an elected community vice-chair who will assume the duties of co-chair at the beginning of the next planning year or if the chair is unable to complete their term. Most planning groups have a planning calendar that begins in October and ends in September. The following is a list of Health Department and Community Co-chairs:

WASHINGTON STATE HIV PREVENTION PLANNING CO-CHAIRS
2001 PLANNING YEAR

REGION 1: (Eastern)

Health Department Co-chair
Barry Hilt
Region 1 AIDSNET Coordinator

Community Co-chair
Muril Demory
Community member

REGION 2: (Central)

Health Department Co-chair:
Wendy Doescher
Region 2 AIDSNET Coordinator
Yakima Health District

Community Co-chair
Debra Severtson-Coffin
Community Member

REGION 3: (Northwest)

Health Department Co-chair:
Ward Hines, M.D.
Health Office
Snohomish Health District

Community Co-chair
Stephan Dorn
Community Member

REGION 4: (Metro Seattle-King County)

Health Department Co-chair
Dr. Bob Wood, M.D.
Public Health - Seattle & King Co.
HIV/AIDS Program

Community Co-chair
Sam Soriano
Community Member

REGION 5: (Pierce/Kitsap County)

Pierce County:

Health Department Co-chair:
Mary Saffold
Region 5 AIDSNET Coordinator
Tacoma, WA 98408-6897

Community Co-chair
Charles Fann
POCAAN (CBO)

Community Vice-chair
Howard Russell
Brother to Brother, Tacoma (CBO)
(Assumed chair August 2001)

Kitsap County

Health Department Co-chair:	Community Co-chair
Lenore Morrey	John Abrams
Bremerton-Kitsap Health District	Community Member

REGION 6: (Southwest)

Health Department Co-chair:	Community Co-chair
Brown McDonald	Clain Lust
Region 6 AIDSNET Coordinator	Community Member

STATE PLANNING GROUP

Health Department Co-chair:	Community Co-chair
Jack Jourden, Director, IDRH	Pamala Sacks
WA State Department of Health	DSHS – DASA
	Community Vice-chair
	Dale Briese
	Spokane AIDS Network (CBO)

In establishing the process of community planning, the CDC clearly considered that PIR (parity, inclusion and representation) was an absolute goal and requirement. Two of the five national objectives for community planning are:

1. **Foster the openness and participatory nature of the community planning process.**

2. **Ensure that the CPG(s) reflects the diversity of the epidemic in your jurisdiction and that expertise in epidemiology; behavioral science, health planning, and evaluation are included in the process.** (Quoted from CDC Guidance)

As you can see from Table 4, the state and regional planning groups have been very successful in achieving these goals. Some major achievements over the past 2 years have included:

1. Increased number of men on several planning groups, including representatives of the infected/affected communities. (+20%)
2. More involvement of people of color on regional planning groups. (+5%)
3. Representation of the transgender community on the Region 4 planning group and subcommittees.
4. Increased numbers of HIV infected members. (+5%)
5. Membership has remained very stable. On many groups, including the SPG, a majority of members have served for at least 2 years.

The unmet membership needs are:

1. Recruiting and retaining members from the Asian and Pacific Islander communities.
2. Representation of corrections and mental health services on the regional planning groups.

Each planning group will continue to monitor the PIR plan and develop strategies to fill any gaps that might exist in representative membership.

All planning groups have a variety of strategies to recruit new members. The SPG recently developed a booklet called "The Little Blue Book" (see Attachment 8) that outlines the community planning process. This booklet can be used to inform prospective members of the planning process. All of the planning groups use word of mouth to recruit new members. Additionally, identified community leaders and experts may be directly recruited. Most planning groups place ads in local newspapers, newsletters and other media to advertise their meetings. Many groups distribute fliers and posters to invite people to come to meetings or join the group.

All meetings of the planning groups are open to the public and are ADA (Americans with Disabilities Act) accessible. All groups can provide ADA accommodation with sufficient notice. All groups support the attendance of their membership by providing reimbursement for mileage and other related expenses. If large distances are involved in attendance, airfare and lodging are also provided. Childcare and other related costs may also be reimbursed.

Each of the planning groups has a charter or by-laws that govern their membership and process. All of the by-laws: 1) establish a membership committee; 2) define conflict of interest and how to deal with it; and, 3) define how decisions are to be made by the group (most rely upon consensus). Most of the planning groups have written procedures for: 1) conflict resolution; 2) maintenance of confidentiality; 3) establishment of committees/ subcommittees; and 4) ground rules for meetings. All groups establish a planning calendar each year.

Every planning group has discussed and developed a parity, inclusion and representation (PIR) Plan on how to make sure that the planning process is available and accessible to those communities impacted by HIV. This might include availability of translators, moving the meeting place around a region, having meetings at different times of the day or week and holding a special meeting on more convenient days or in more convenient locations.

Communication between the SPG and the RPG's is facilitated by the RPG representatives on the SPG. It is their role to bring information to the SPG about their respective regions and to take information back to their RPG on decisions and guidance developed at the SPG. Additionally, a staff member from DOH is often present at the regional meetings to provide technical assistance and clarification of information or process.

DOH HIV Prevention and Education and Services publish a quarterly newsletter, *Washington State Responds (WSR)*. *WSR* informs and educates stakeholders and the public on HIV and other infectious disease and reproductive health topics. Each edition of *WSR* features information on surveillance data, STD, TB Family Planning and other related public health issues. Updates on the community planning process and feature articles on prevention are also included. This publication is mailed to over 1500 people in the state. Additional information on community planning is also available on the HIV Prevention and Education website at www.doh.wa.gov/cfh/hiv/htm.

WHAT

WE

DECIDED

WHAT WE DECIDED

BEHAVIORAL RISK CATEGORIES

The State Planning Group (SPG) is responsible for determining the priority order of the Behavioral Risk Categories. These reflect the statewide picture and are for guidance to the regional groups. The Behavioral Risk Category priorities are:

1. MSM – Men who have sex with men

The behavioral risk category includes all behaviors that involve sexual activities between men. Such behaviors include anal and oral intercourse. Specific behaviors that might increase the risk of HIV transmission could include unprotected anal or oral sex (not using a condom), multiple or anonymous partners of unknown serostatus, and sharing of sex 'toys,' Whether the person identifies as gay, bisexual, heterosexual or other sexual identity, if he participates in sexual activity with other men, he fits in this category.

2. IDU – Injection Drug User

The behavioral risk category includes all behaviors associated with injecting legal and illegal substances intravenously, intramuscularly or subcutaneously. The primary risk for HIV transmission is from sharing the injection equipment with another person, who is HIV+.

3. HETEROSEXUAL (HET)

This behavioral risk category includes all behaviors that involve sexual intercourse between male and female partners. Such behaviors include unprotected anal, vaginal, and oral intercourse. The highest risk behaviors involve unprotected sex with sero-positive partners, followed by partners who are either MSM or IDU.

NOT PRIORITIZED – PREGNANT WOMEN

The SPG also determined that perinatal transmission of HIV from HIV+ mothers to their unborn and infant children is not a behavioral risk category to be addressed in the state plan. While perinatal transmission is a concern, the prevention of this transmission is clearly a treatment issue. It is recommended that pre or perinatal HIV testing be available and encouraged as a prevention strategy for pregnant women. To this end, the SPG has endorsed the recommendations of the Maternal/Child Health Consumer Advisory Group to change state law to allow HIV testing of pregnant women to be part of a standard screening test panel, unless the women specifically refuses the HIV antibody test. Public input on this rule change is presently being taken and is generally supportive.

The regional planning groups have ranked the behavioral risk categories as follows:

TABLE 5
Rank order of Behavioral Risk Categories by Planning Group

SPG	Region 1	Region 2	Region 3	Region 4	Region* 5-Kitsap	Region* 5-Pierce	Region 6
MSM	MSM	MSM	MSM	MSM	MSM	IDU	IDU
IDU	IDU	HET	IDU	IDU	IDU	MSM	MSM
HET	HET	IDU	HET	HET	HET	HET	HET

*Region 5 has 2 separate community planning groups (CPG) in Kitsap and Pierce Counties

The decision by the Region 2 planning group to rank heterosexuals above IDUs was based on their epi profile and the more recent HIV reporting data. The decision by Region 5-Pierce County to prioritize IDU above MSM was based on their epi profile data indicating that the percentages of people living with AIDS (PLWA) and new HIV+ people in all three behavioral risk categories were very close. Using riskiness of behavior and trend data, the planning group selected IDU as a slightly higher priority than MSM. The decision in Region 6 to rank IDU above MSM was based on discussion of the riskiness of behavior and the strong belief by the planning group that IDU's were the highest priority in the region.

TARGET POPULATIONS (used interchangeably with population in the plan)

Regions 1, 3 and Region-Pierce County reconfirmed their previous prioritization process as an update to their previous plan. Regions 2, 4, 6 and Region 5-Kitsap County are in the first year of a new planning cycle and established their priorities through a decision making process. Regions 1, 2, 3, 4 and Region 5-Kitsap County discussed or determined the priority order of their identified target populations. Region 6 and Region 5-Pierce County discussed the prioritization, but chose to list their populations in alphabetical order in the plan.

Utilizing these prioritization data and the discussions of the regional planning group meetings, the following tables list the apparent priorities for target populations for the state. These priority lists may include populations not listed in the specific regional plan or combinations of two identified populations. All 7 planning groups identified the first five populations for MSM and IDU in their plan. The first three priority populations for Heterosexual were also represented in all regional plans.

TABLE 6
Washington MSM Behavioral Risk Category Populations

MSM – Men Who Have Sex with Other Men	
PRIORITY	**POPULATION**
1	MSM – general
2	HIV+ MSM and partners
3	Young MSM <24
4	MSM/IDU *
5	Men of Color:
	African American
	Hispanic/Latino
	American Indian
6	Non (-Self) Identifying MSM
7	Rural MSM **
8	Incarcerated MSM
9	Migrant (Latino) MSM (May be included in Men of Color)
10	Multiple sex partners, HIV- or unknown serostatus
11	Sex Traders

* MSM/IDU are person with equal risk due to MSM and IDU behaviors. They are listed under MSM, but the interventions targeting this population must address both behaviors.
**Rural MSM may fall into any of the other populations

TABLE 7
Washington IDU Behavioral Risk Category Priority Populations

IDU – Injecting Drug Users	
PRIORITY	**POPULATION**
1	IDU – general
2	HIV+ IDU and partners
3	Young IDU <24
4	Men of Color:
	African American
	Hispanic/Latino/a
5	Needle Sharing
6	Homeless IDU or IDU involved with the legal system, including incarcerated
7	Survival sex or partners of IDU
8	Methamphetamine users
9	Rural IDU *

* Rural IDU may fall into any of the other populations

TABLE 8
Washington Heterosexual Behavioral Risk Category Priority Populations

HETEROSEXUAL	
PRIORITY	**POPULATION**
1	HIV+ and partners
2	Youth <24
3	Persons of Color
	African American
	Latino/a
4	Female partners of high risk males or survival sex
5	Incarcerated
6	High risk or of unknown serostatus

A complete summary of target populations by region begins on page _____.

EFFECTIVE INTERVENTIONS

The SPG considered the possible effective interventions available in the scientific and behavioral literature for the various behavioral risk categories and potential populations. Through review of the literature and discussion with our expert members and advisors, the following effective interventions matrix was adopted. This matrix was developed to guide the regional planning groups in the selection of effective interventions for their region. The intervention types listed in this matrix are prioritized for the general behavioral risk category.

Regional planning groups could adopt this matrix or prioritize their own interventions. In general, the RPG used this matrix as their basis for effective intervention recommendations. As part of the decision making process for Region 4, Public Health-Seattle & King County staff developed a review of the literature. This review was distributed to all planning groups and can be found as Attachment 2 of this plan.

On March 26, 2001, the SPG prioritized the recommendation for intervention types by behavioral risk category. The matrix (Table 9) is the result of that decision making process. This matrix was distributed to the regional planning groups and they had the option of adopting its recommendations for their prioritized behavioral risk categories or specifying their own priorities for their populations.

TABLE 9
PRIORITIZED EFFECTIVE INTERVENTION TYPES BY BEHAVIORAL RISK CATEGORY

HIV+ /partners - Urban & Rural				
	HERR	**HC/PI**	**CTR/PCRS**	**PCM**
1	Groups Individual Level		Targeted CTR PCRS "Person @risk"	PCM
2	Community Level Intervention (Communities of color)	Social Marketing Mass Media & Other Media		
3		Hotline/Clearinghouse		

MSM – Urban and Rural			
	HERR	**HC/PI**	**CTR/PCRS**
1	Community level Interventions Group level Interventions		CTR-high risk PCRS
2	Street/Community Outreach Individual level Interventions	Social Marketing Mass Media & Other Media	
3		Hotline/Clearinghouse	

IDU – Urban and Rural			
	HERR	**HC/PI**	**CTR/PCRS**
1	Needle Exchange Community level Interventions		CTR-high risk PCRS
2	Individual level Interventions Street/Community Outreach		
3	Group level Interventions	Mass Media & Other Media Social Marketing Hotline/Clearinghouse	

HETEROSEXUAL - Urban			
	HERR	**HC/PI**	**CTR/PCRS**
1	Community level Interventions Group level Interventions Street/Community Outreach		CTR-high risk PCRS
2	Individual level Interventions	Mass Media & Other Media Social Marketing	
3		Hotline/Clearinghouse	

HETEROSEXUAL - Rural			
	HERR	**HC/PI**	**CTR/PCRS**
1	Community level Interventions Group level Interventions	Mass Media & Other Media Social Marketing	CTR- high risk PCRS
2	Individual level Interventions Street/Community Outreach		
3		Hotline/Clearinghouse	

For a complete explanation of abbreviations see pages 58-59 or Attachment 7. (4/26/01)

According the Ellensburg Document, 10% of the CDC funding (of no less that $250,000 and no more than $400,000) are to be 'set-aside' for projects of statewide significance. It is the responsibility of the state planning group (SPG) to establish the priorities for use of these funds. The following is the priority list established by the SPG:

TABLE 10
Washington State Priorities for CDC Set-Aside Resources

PRIORITIES FOR 'SET-ASIDE' PROJECTS – 2002-2003	
1	Continue technical assistance and training to the field
2	Needs Assessment: Young gay men of color
3	Continue support of new technologies for HIV anti-body testing, with increase in access to oral fluid testing and exploration of rapid testing technologies
4	Based on needs assessment, implement seasonal farm worker pilot intervention(s)
5	Develop and implement recommendations for interventions for rural IDU populations

Each planning group was surveyed to determine the types of technical assistance they believed was the most important. All planning groups responded with at least a list of needs, and several prioritized these needs. Based on this information, following are the recommendations for technical assistance:

Community Planning Group needs:

- Identification of effective rural interventions for target populations
- Methods of determining populations
- Clarification of the tools of community planning, including community resource inventory (CRI), cost effectiveness and gap analysis
- Recruiting and retaining infected/affected and communities of color members on the planning group
- Effective intervention and prevention technology updates
- Needs assessment data for populations

Prevention needs:

- Effective interventions for rural populations
- Program evaluation and outcome monitoring
- Cultural barriers to HIV prevention

WHY WE MADE THE DECISIONS

WHY WE MADE THE DECISIONS

The basis for all decision making for HIV prevention is the epidemiologic (epi) data. These data tell you:

- how many people have been infected or diagnosed with HIV/AIDS
- where they were diagnosed
- when they were diagnosed
- if they are still living
- what the behavior(s) are that put them at risk
- the general characteristics of who they are, and
- other information that helps you understand this epidemic.

Since 1993, the HIV Assessment Unit at the Washington State Department of Health has developed specific epidemiologic reports for each region and the state. The report for Region 4 (Seattle-King County) has been a joint effort by both DOH and Public Health – Seattle & King County (PHSKC).

For the 2002-2003 planning cycle, Regions 1, 2, 3, 5 and 6 received copies of regional epi profiles and a presentation from Maria Courogen, the Assessment Unit lead epidemiologist. The Prioritization Committee for the Region 4 (Seattle-King County) planning group received written materials and oral presentations from the PHSKC epi staff. (See Attachment 4 for copies of these reports.)

For the purpose of the plan, the data in these reports has been combined to develop the tables in this chapter. A complete state epidemiologic plan is still in development and will be issued in the fall of 2001.

WHAT'S NEW?

Nationally, the reported numbers of AIDS cases have declined due to the impact of highly active antiretroviral therapy (HAART). These medications and procedures have been prescribed since the mid-1990's. Since late 1998, their effects have slowed, resulting in a "stalling" of the trends at both the local and national levels. Reasons for this may include:

- reaching the limits of therapy in helping people live longer
- failing therapies due to treatment-resistant viral strains
- late HIV testing
- inadequate access to and adherence to treatment in some populations
- recent increases in HIV incidence in some risk groups.

All of these factors have brought new challenges in prevention efforts.

As people have lived longer and looked healthier, they have been able to return to more normal lives. This created a double-edged sword. On one hand, it is great to feel better; on the other hand, the critical nature of the infection becomes less clear. Many young people have never seen a person with full-blown AIDS or attended a funeral of someone

who has died of AIDS. This can give a false sense of freedom from the risks of HIV infection. Many communities choose to believe the new HIV treatments are a 'cure.' This reality makes knowledge of HIV status even more critical and generates great discussions about the importance of HIV reporting.

In terms of data collection, the biggest change in Washington was the initiation of HIV reporting in September of 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were seen, in part, by the parallel AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact (see Table 11). Additionally, implementing HIV reporting may have resulted in better reporting of AIDS cases due to increased lab reporting and general awareness by the medical community.

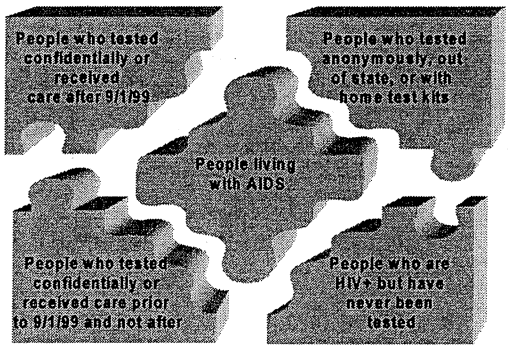
While there have been shifts in the epidemic, there have also been continuing concerns about the traditional risk factors, populations, and issues. Although seroprevalence rates and case numbers for men who have sex with men (MSM) have been decreasing, there are some indications that this population is experiencing increases in high risk behaviors that could reverse these trends. Between 1997 and 2000 nationally and in King County, as well as some other urban settings, STD rates have substantially increased among MSM populations. Studies of these populations have also indicated that unprotected anal sex and the numbers of partners have significantly increased for young MSM and MSM of color. All of these indicators support the message that behavioral change is still the primary method for preventing the transmission of HIV.

By comparing the general population numbers (demographics) with the HIV and AIDS data, it is possible to begin forming a picture of this epidemic in each region and throughout the state (see Table 1).

HIV Data

Preliminary HIV reporting data through 12/31/2000, describe asymptomatic (no symptoms) HIV cases reported to DOH as a result of the new reporting requirement, as well as symptomatic cases, which have been reported since 1987. All people living with HIV infection will fall into one of the 5 categories indicated in Figure 1.

Figure 1. People living with HIV infection



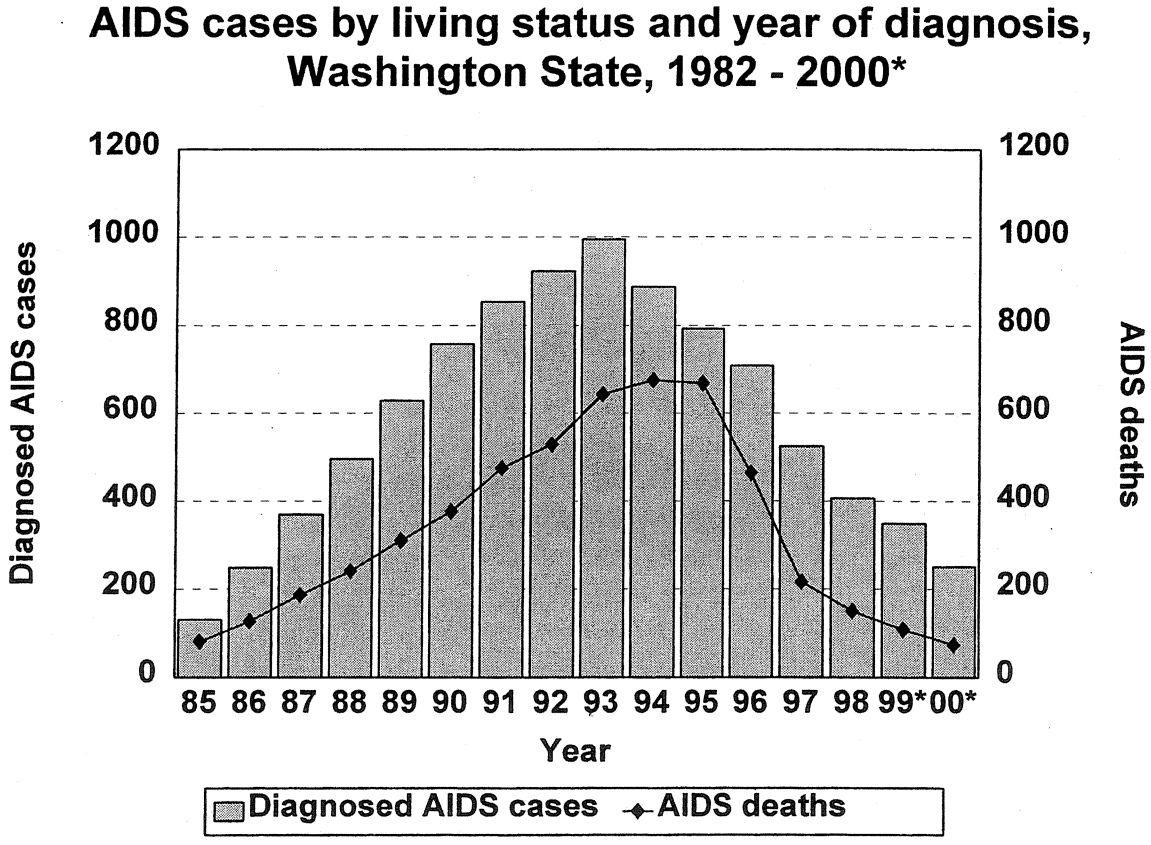
To understand the data reported on Table 11, it is important to understand both their strengths and limitations. HIV data resulting from HIV reporting:

- Provide a *minimum estimate* of the number of HIV+ persons
- Describe those who are at an earlier point in their infection
- Do **not** effectively describe those who are newly infected (that is, do not give incidence information). The data system gathers the data at whatever point in the infection process that the person decides to be tested, rather than determining the actual point of infection. Therefore, HIV+ data could represent infections that are from weeks to years old.
- HIV data are not representative of all HIV-infected individuals. The universe of all HIV infected individuals is made up of the 5 categories in Figure 1.
- This information may not be available or complete for some groups. These data are considered to be >90% complete. There are people who know their HIV status because they tested anonymously, in another state, or with a home test kit and their information would not be included.
- The information for people who tested or received care prior to 9/1/99, but not after, will also not be included.
- Finally, there are those who have never been tested and are HIV infected, but do not know their status.

Preliminary data from each region and county indicate that HIV cases have been reported in all counties except Ferry, Garfield, Kittitas, Klickitat, Lincoln, Pacific, and Skamania. The year of diagnosis (earliest possible test result) ranges from 1984 to 2000. When compared to recently diagnosed cases of AIDS, the HIV cases include a higher proportion of women, people of color, and cases in people under the age of 30. HIV cases also include a higher proportion of cases with no identified risk. This is due to the earlier diagnosis in the course of the infection, the fact that people may not be aware of their risk factors and that people may not share information with a provider. Additionally, many cases of HIV are identified through laboratory reporting where associated risk factors are more difficult to track or determine.

Trends in AIDS cases and deaths

Starting in mid-1990, the number of reported AIDS cases and AIDS deaths decreased at an astounding rate. Figure 2 shows the declines and also shows the previously indicated 'stalling' of the trends starting in 1998.



With this decrease in the number of reported death of people with AIDS, the number of people living with AIDS (AIDS prevalence) has increased. This means that the proportion of people living with AIDS, after diagnosis, has steadily increased. Over the years this has contributed to a change in the trends of AIDS cases in each region and the state. Table 12 summarizes these changes.

Table 11
HIV cases reported as of 12/31/00

	WA State N = 2,081	Region 1 N = 105	Region 2 N = 66	Region 3 N = 171	Region 4 N = 1,334	Region 5 N = 254	Region 6 N = 151
Year of diagnosis							
1982-89	353 (17%)	23 (22%)	13 (20%)	23 (13%)	239 (18%)	35 (14%)	20 (13%)
1990-95	768 (37%)	35 (33%)	20 (30%)	70 (41%)	480 (36%)	103 (41%)	60 (40%)
96	151 (7%)	8 (8%)	5 (8%)	19 (11%)	90 (7%)	17 (7%)	12 (8%)
97	179 (9%)	9 (9%)	6 (9%)	19 (11%)	109 (8%)	22 (9%)	14 (9%)
98	145 (7%)	10 (10%)	4 (6%)	7 (4%)	109 (8%)	6 (2%)	9 (6%)
99	248 (12%)	10 (10%)	13 (20%)	19 (11%)	156 (12)	29 (11%)	21 (14%)
00	237 (11%)	10 (10%)	5 (8%)	14 (8%)	151 (11)	42 (17%)	15 (10%)
							Gender
Male	1727 (83%)	86 (82%)	45 (68%)	132 (77%)	1168 (88%)	180 (71%)	116 (77%)
Female	354 (17%)	19 (18%)	21 (32%)	39 (23%)	166 (12%)	74 (29%)	35 (23%)
							Race/Ethnicity
White	1546 (74%)	82 (78%)	40 (61%)	142 (83%)	982 (74%)	173 (68%)	127 (84%)
Black	279 (13%)	11 (10%)	4 (6%)	12 (7%)	198 (15%)	45 (18%)	9 (6%)
Hispanic	160 (8%)	5 (5%)	21 (32%)	6 (4%)	100 (8%)	23 (9%)	5 (3%)
Asian/Pacific Is.	40 (2%)	0 (0%)	0 (0%)	6 (4%)	26 (2%)	5 (2%)	3 (2%)
AmerInd/AlaskNat	38 (2%)	3 (3%)	0 (0%)	5 (3%)	22 (2%)	7 (3%)	1 (1%)
Unknown	18 (1%)	4 (4%)	1 (2%)	0 (0%)	6 (<1%)	1 (<1%)	6 (4%)
							Mode of exposure
MSM	1205 (58%)	44 (42%)	29 (39%)	83 (49%)	893 (67%)	96 (38%)	63 (42%)
IDU	253 (12%)	21 (20%)	12 (18%)	23 (13%)	100 (8%)	73 (29%)	24 (16%)
MSM/IDU	211 (10%)	11 (10%)	7 (11%)	13 (8%)	143 (11%)	25 (10%)	12 (8%)
Heterosexual	164 (8%)	12 (11%)	10 (15%)	27 (16%)	57 (4%)	33 (13%)	25 (17%)
Blood products	20 (1%)	0 (0%)	3 (5%)	1 (1%)	10 (1%)	4 (2%)	2 (1%)
Other/Unknown	228 (11%)	17 (16%)	8 (12%)	24 (14%)	131 (10%)	23 (9%)	25 (17%)
							Age at HIV diagnosis
<13	31 (1%)	3 (3%)	2 (3%)	4 (2%)	16 (1%)	3 (1%)	3 (2%)
13-19	66 (3%)	2 (2%)	6 (9%)	6 (4%)	31 (3%)	8 (3%)	3 (2%)
20-29	723 (35%)	45 (43%)	25 (38%)	57 (33%)	452 (34%)	95 (37%)	49 (32%)
30-39	831 (39%)	30 (29%)	24 (36%)	65 (38%)	557 (42%)	99 (39%)	56 (37%)
40-49	341 (16%)	19 (18%)	6 (9%)	29 (17%)	217 (16%)	37 (15%)	33 (22%)
50-59	80 (4%)	6 (6%)	3 (5%)	10 (6%)	45 (3%)	12 (5%)	5 (3%)
60+	9 (<1%)	0 (0%)	0 (0%)	0 (0%)	6 (<1%)	0 (0%)	2 (1%)

TABLE 12
AIDS Trends data between 1985-89 to 1995-1999

	95-99 Region 1	Chg From 85-89	95-99 Region 2	Chg From 85-89	95-99 Region 3	Chg From 85-89	95-99 Region 4	Chg From 85-89	95-99 Region 5	Chg From 85-89	95-99 Region 6	Chg From 85-89	95-99 State	Chg From 85-89
Gender														
Male	90%	-5%	86%	-7%	83%	10%	92%	-6%	75%	-19%	85%	-9%	88%	-9%
Female	10%	+5%	14%	+7%	17%	+10%	8%	+6%	25%	+19%	15%	+9%	12%	+9%
Exposure														
MSM	49%	-16%	47%	-10%	48%	-23%	67%	-14%	40%	-25%	50%	-10%	58%	-18%
IDU	20%	+10%	12%	-2%	13%	+8%	8%	+5%	24%	+18%	21%	+11%	14%	+9%
MSM/IDU	10%	-4%	8%	-17%	8%	-7%	9%	-2%	8%	-7%	7%	-6%	9%	-3%
Hetero	8%	+8%	18%	+18%	15%	+13%	5%	+4%	15%	+13%	12%	+8%	8%	+6%
Blood pdt	3%	-6%	3%	-2%	4%	0%	1%	1%	2%	-6%	2%	-10%	%2	-2%
Oth/unk	11%	+8%	13%	+13%	14%	+10%	12%	+10%	11%	+9%	8%	+7%	10%	+8%
Race/Eth														
White	83%	-6%	62%	-15%	81%	-11%	72%	-15%	67%	-14%	81%	-14%	73%	-14%
Af/Amer	5%	+1%	4%	-1%	7%	+4%	14%	+7%	21%	+8%	7%	+6%	13%	+6%
API	0%	0%	0%	0%	3%	+3%	2%	0%	3%	+2%	9%	+6%	2%	+1%
AI	2%	+1%	0%	0%	5%	+5%	2%	+1%	3%	+2%	1%	0%	3%	+2%
Hispanic	85	+2%	34%	+18%	4%	+4%	9%	+5%	6%	+2%	1%	+1%	9%	+5%

For more detail, please refer to Regional Epi Profiles in Attachment 4

Table 13 - People Living with AIDS as of 12/31/00

	WA State N = 4,060	Region 1 N = 242	Region 2 N = 136	Region 3 N = 337	Region 4 N = 2,519	Region 5 N = 457	Region 6 N = 369
Year of diagnosis							
1984-89	133 (3%)	7 (3%)	4 (3%)	2 (1%)	100 (4%)	12 (3%)	8 (2%)
1990-95	1938(48%)	104 (43%)	49 (36%)	158 (47%)	1290 (51%)	164 (36%)	173 (47%)
96	615 (15%)	38 (16%)	22 (16%)	52 (15%)	373 (15%)	73 (16%)	57 (15%)
97	462 (11%)	28 (12%)	21 (15%)	42 (12%)	257 (10%)	66 (14%)	48 (13%)
98	367 (9%)	13 (5%)	16 (12%)	37 (11%)	231 (9%)	44 (10%)	26 (7%)
99	316 (8%)	29 (12%)	10 (7%)	28 (8%)	168 (7%)	49 (11%)	32 (9%)
00	229 (6%)	23 (10%)	14 (10%)	18 (5%)	100 (4%)	49 (11%)	25 (7%)
Gender							
Male	3633 (89%)	224 (93%)	114 (84%)	282 (84%)	2347 (93%)	349 (76%)	317 (86%)
Female	427 (11%)	18 (7%)	22 (16%)	55 (16%)	172 (7%)	108 (24%)	52 (14%)
Race/Ethnicity							
White	3044 (75%)	197 (81%)	78 (57%)	277 (82%)	1878 (75%)	308 (67%)	306 (83%)
Black	483 (12%)	10 (4%)	4 (3%)	20 (6%)	332 (13%)	90 (20%)	27 (7%)
Hispanic	362 (9%)	17 (7%)	51 (38%)	20 (6%)	214 (9%)	35 (8%)	25 (7%)
Asian/Pacific Is.	74 (2%)	2 (1%)	1 (1%)	8 (2%)	47 (2%)	11 (2%)	5 (1%)
AmerInd/AlaskNat	89 (2%)	9 (4%)	2 (1%)	12 (4%)	48 (2%)	13 (3%)	5 (1%)
Unknown	8 (<1%)	7 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Mode of exposure							
MSM	2560 (63%)	129 (53%)	68 (50%)	179 (53%)	1795 (71%)	199 (44%)	190 (51%)
IDU	450 (11%)	44 (18%)	15 (11%)	33 (10%)	180 (7%)	100 (22%)	78 (21%)
MSM/IDU	374 (9%)	24 (10%)	12 (9%)	30 (9%)	242 (10%)	38 (8%)	28 (8%)
Heterosexual	303 (7%)	15 (6%)	20 (15%)	48 (14%)	116 (5%)	68 (15%)	36 (10%)
Blood products	62 (2%)	5 (2%)	2 (1%)	11 (3%)	24 (1%)	9 (2%)	10 (3%)
Other/Unknown	311 (8%)	25 (10%)	19 (15%)	36 (11%)	162 (6%)	43 (10%)	27 (7%)
Age at AIDS diagnosis							
<13	14 (<1%)	1 (<1%)	1 (1%)	0 (0%)	7 (<1%)	4 (1%)	1 (<1%)
13-19	18 (<1%)	3 (1%)	0 (0%)	2 (1%)	4 (<1%)	5 (1%)	4 (1%)
20-29	740 (18%)	39 (16%)	48 (35%)	59 (18%)	442 (18%)	88 (19%)	64 (17%)
30-39	1933 (48%)	109 (45%)	50 (37%)	152 (45%)	1242 (49%)	207 (45%)	173 (47%)
40-49	1021 (25%)	60 (25%)	24 (18%)	96 (28%)	634 (25%)	110 (24%)	97 (26%)
50-59	269 (7%)	25 (10%)	12 (9%)	20 (6%)	161 (6%)	35 (8%)	16 (4%)
0+	65 (2%)	5 (2%)	1 (1%)	8 (2%)	29 (1%)	8 (2%)	14 (4%)

Table 14 - Cumulative AIDS as of 12/31/00

	WA State N = 9,421	Region 1 N = 520	Region 2 N = 298	Region 3 N = 739	Region 4 N = 6,092	Region 5 N = 1,005	Region 6 N = 767
Year of diagnosis							
1982-89	1975 (21%)	80 (15%)	49 (16%)	113 (15%)	1449 (24%)	173 (17%)	111 (14%)
1990-95	5207 (55%)	290 (56%)	149 (50%)	414 (56%)	3390 (56%)	521 (52%)	443 (58%)
96	708 (8%)	44 (8%)	27 (9%)	70 (9%)	418 (7%)	82 (8%)	67 (9%)
97	526 (6%)	32 (6%)	25 (8%)	51 (7%)	295 (5%)	70 (7%)	53 (7%)
98	407 (4%)	17 (3%)	21 (7%)	41 (6%)	250 (4%)	50 (5%)	28 (4%)
99	348 (4%)	33 (6%)	12 (4%)	31 (4%)	179 (3%)	54 (5%)	39 (5%)
00	250 (3%)	24 (5%)	15 (5%)	19 (3%)	111 (2%)	55 (5%)	26 (3%)
Sex							
Male	8705 (92%)	484 (93%)	258 (87%)	647 (88%)	5799 (95%)	841 (84%)	676 (88%)
Female	716 (8%)	36 (7%)	40 (13%)	92 (12%)	293 (5%)	164 (16%)	91 (12%)
Race/Ethnicity							
White	7527 (80%)	447 (86%)	198 (66%)	630 (85%)	4878 (80%)	702 (70%)	672 (88%)
Black	925 (10%)	21 (4%)	12 (4%)	34 (5%)	632 (10%)	192 (19%)	34 (4%)
Hispanic	628 (7%)	28 (5%)	83 (28%)	36 (5%)	374 (6%)	70 (7%)	37 (5%)
Asian/Pacific Is.	162 (2%)	3 (1%)	1 (<1%)	16 (2%)	117 (2%)	19 (2%)	6 (1%)
AmerInd/AlaskNat	167 (2%)	13 (3%)	4 (1%)	22 (3%)	91 (1%)	21 (2%)	16 (2%)
Unknown	12 (<1%)	8 (2%)	0 (0%)	1 (<1%)	0 (0%)	1 (<1%)	2 (<1%)
Mode of exposure							
MSM	6442 (68%)	305 (59%)	155 (52%)	430 (58%)	4596 (75%)	510 (51%)	446 (58%)
IDU	846 (9%)	78 (15%)	37 (12%)	82 (11%)	346 (6%)	183 (18%)	120 (16%)
MSM/IDU	941 (10%)	51 (10%)	34 (11%)	77 (10%)	623 (10%)	95 (9%)	61 (8%)
Heterosexual	496 (5%)	30 (6%)	32 (11%)	69 (9%)	194 (3%)	101 (10%)	70 (9%)
Blood products	205 (2%)	20 (4%)	9 (3%)	26 (4%)	83 (1%)	36 (4%)	31 (4%)
Other/Unknown	491 (5%)	36 (7%)	31 (10%)	55 (7%)	250 (4%)	80 (8%)	39 (5%)
Age at AIDS diagnosis							
<13	33 (<1%)	2 (<1%)	2 (1%)	4 (1%)	15 (<1%)	9 (1%)	1 (<1%)
13-19	37 (<1%)	5 (1%)	5 (2%)	3 (<1%)	12 (<1%)	7 (1%)	5 (1%)
20-29	1704 (18%)	94 (18%)	75 (25%)	130 (18%)	1040 (17%)	228 (23%)	137 (18%)
30-39	4403 (47%)	238 (46%)	113 (38%)	318 (43%)	2955 (49%)	449 (45%)	330 (43%)
40-49	2339 (25%)	110 (21%)	70 (23%)	207 (28%)	1530 (25%)	214 (21%)	208 (27%)
50-59	685 (7%)	54 (10%)	25 (8%)	49 (7%)	433 (7%)	73 (7%)	51 (7%)
60+	220 (2%)	17 (3%)	8 (3%)	28 (4%)	107 (2%)	25 (2%)	35 (5%)

HIV/AIDS in behaviorally defined populations

Table 14 summarizes the data on cumulative (for the entire epidemic) AIDS cases in each region and the state. These data give a picture of the total epidemic. If we subtract out those persons in the data that we know have died, we can then look at the data that describes people presently living with AIDS in each region and state, Table 13. The picture of the epidemic changes slightly with a review of the data for people living with AIDS, as opposed to the cumulative data (Table 15). While MSM are still the most common risk factor for contracting HIV, the relative proportion of MSM has decreased. The number of cases attributed to both MSM and IDU behavior (MSM/IDU) has remained steady throughout the reported data. As a result of these decreases, balancing increases have been seen in other populations. IDU cases have increased in 5 regions and heterosexual cases have increased in all six regions. The number of cases in women (proportionally) has increased as cases in men have decreased. For HIV cases, diagnosis has been 10 years earlier than AIDS diagnoses, as would be anticipated by the normal course of the disease. In terms of racial and ethnic groups, cases in whites have decreased, while cases in communities of color have increased. Table 12 is a summary of the changes in the various demographics of the epidemic between the time periods 1985-89 and 1995-1999. The following table (Table15) is a comparison of the cumulative AIDS data and the people living with AIDS as of December 31, 2000. The data on people living with AIDS not only reflects the people who are still alive, but also people who have probably been infected more recently in the epidemic. Clearly indicated are increases in the number of women. Increases in the African American, Hispanic, IDU, and heterosexual categories are also indicated. There was no change in the age of diagnosis.

TABLE 15
Comparison of cumulative AIDS cases and number of people living with AIDS in Washington State as of December 31, 2000

	Cumulative AIDS cases N = 9,421	% total of cumulative AIDS cases	People living with AIDS N = 4,060	% total of people living with AIDS
Gender				
Male	8705	92%	3633	89%
Female	716	8%	427	11%
Race/Ethnicity				
White	7527	80%	3044	75%
Black	925	10%	483	12%
Hispanic	628	7%	362	9%
Asian/Pacific Is	162	2%	74	2%
Amerind/AlaskNat	167	2%	89	2%
Unknown	12	<1%	8	<1%
Mode of exposure				
MSM	6442	68%	2560	63%
IDU	846	9%	450	11%
MSM/IDU	941	10%	374	9%
Heterosexuals	496	5%	303	7%
Blood products	205	2%	62	2%
Other/unknown	491	5%	311	8%

Age of AIDS diagnosis				
<13	33	<1%	14	<1%
13-19	37	<1%	18	<1%
20-29	1704	18%	740	18%
30-39	4403	47%	1933	48%
40-49	2339	25%	1021	25%
50-59	685	7%	269	7%
60+	220	2%	65	2%

A comparison of people living with AIDS by gender and mode of transmission (Table 16, next page) also helps to understand the differences between the genders in this epidemic. Men, of course, are distributed between all of the modes of transmission with MSM still in the majority. Women face their highest risk from partners who are HIV+ due, primarily, to transmission from their own MSM or IDU behaviors. The second significant mode of transmission for women is their own IDU behaviors. Knowing, however, that to be categorized as a heterosexual transmission, the risk of the partner must be known, the high number of women who report 'other or no known risks' may eventually be identified as heterosexual transmission (if their partner can be identified and confirmed as HIV+). These data link HIV in women with the risk behaviors of their male partners.

Another area of concern nationally and locally is the increasing cases of HIV and AIDS among people of color, especially among African American and Hispanic communities (Table 17). The following data on mode of transmission and race/ethnicity for people living with HIV was considered (specifically for each region). The total state data reflects the trends in all regions. Regional data can be reviewed in Attachment 4.

TABLE 16
People living with HIV by mode of transmission and race/ethnicity in the state of Washington as of December 31, 2000 (N (% of that race/ethnicity))

	White	African Amer	Hispanic	Asian/Pac Islander	American Ind/Alaska Nat.
MSM	2097(69%)	188(39%)	191 (53%)	47 (64%)	30 (34%)
IDU	269 (9%)	97 (20%)	53 (15%)	3 (4%)	26 (30%)
MSM/IDU	300 (10%)	29 (6%)	20 (5%)	1 (<1%)	24 (27%)
Heterosexual	172 (6%)	73 (15%)	44 (12%)	7 (9%)	5 (6%)
Blood pdts	49 (2%)	3 (1%)	6 (2%)	3 (4%)	0 (0%)
Other/unk	149 (5%)	89 (19%)	47 (13%)	13 (18%)	3 (3%)
Total	3036	479	361	74	88

Table 17

Mode of transmission by gender for Washington State and Regions of people living with AIDS. (Cases reported as of December 31, 2000, case reporting for 1999 and 2000 is still not considered to be complete)

MODE	FEMALES								MALES								
	1	2	3	4	5-Kit	5-Pi	6	TOT	1	2	3	4	5-Kit	5-Pi	6	TOT	STATE
MSM									129	68	179	1795	38	161	190	2560	2560
									58%	60%	63%	76%	63%	56%	60%	71%	63%
IDU	7	5	9	53	3	38	18	133	38	10	24	127	5	54	58	317	450
	35%	24%	16%	32%	27%	40%	35%	32%	17%	9%	9%	5%	8%	19%	18%	9%	11%
MSM/ IDU									24	12	30	242	10	28	28	374	374
									11%	11%	11%	10%	17%	10%	9%	10%	9%
HET	0	12	36	78	5	40	23	203	6	8	12	38	1	22	13	100	303
	53%	57%	65%	47%	45%	40%	45%	49%	3%	7%	4%	4%	2%	8%	4%	3%	7%
Blood Products	0	0	2	5	1	2	1	11	5	2	9	19	2	4	9	51	62
	0%	0%	4%	3%	9%	2%	2%	3%	2%	2%	3%	1%	3%	1%	3%	1%	2%
Other/ unknown	2	4	8	31	2	16	9	71	22	14	28	124	4	17	18	226	297
	12%	19%	15%	19%	18%	17%	18%	17%	10%	12%	10%	5%	7%	6%	6%	6%	7%
TOTAL	18	21	55	167	11	96	16	418	224	114	282	2345	60	286	316	3628	4046
	4%	5%	13%	40%	3%	23%	4%	10%	6%	3%	8%	65%	2%	8%	9%	90%	100%

All regions have identified youth (<24) as a priority populations. Table 18 describes the number and percent of AIDS cases in people under the age of 24 by mode of transmission.

TABLE 18
Mode of HIV exposure by regions among adolescent and young adults (13-24 years) by region 1983-2000.

MODE	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	TOTAL (mode)
MSM	11(39%)	10(34%)	9 (36%)	94(58%)	28(41%)	20(51%)	172(49%)
IDU	3 (11%)	3 (10%)	1 (4%)	13 (8%)	10(14%)	4(10%)	34(10%)
MSM/IDU	4 (14%)	3 (10%)	4 (16%)	26(16%)	8(12%)	1 (3%)	46(13%)
Heterosexual	4 (14%)	6 (21%)	5 (20%)	11 (7%)	7(10%)	6(15%)	39(11%)
Blood prdts	5 (18%)	3 (10%)	3 (12%	8 (5%)	8(12%)	4(10%)	31 (9%)
Other/unk	1 (4%)	4 (14%)	3 (12%)	10 (6%)	8(12%)	4(11%)	30 (9%)
TOTAL (Region)	28 (8%)	29 (8%)	25 (7%)	162(46%)	69(20%)	39(11%)	352

Percentages in regional data reflect % in region (column) or total. Percentages in last row (TOTAL – region) reflect % of adolescent cases in region.

Additionally, all planning groups have received epi profile information and data on surrogate measures that they might consider in their decision making process. These measures include STD, TB, Hepatitis B and C, and teen pregnancy data. Please refer to Attachment 3 for more details.

GAP ANALYSIS

Draft guidance for gap analysis was developed in 2000-2001. This guidance was presented at the Community Planning Summit in Houston, TX in March of 2001. Several regional planning groups have begun completing the gap analysis for their region. Region 2 has completed the section on MSM and will be seeking information to clarify unanswered questions. Region 3 has begun the process of gathering the information needed to complete the analysis. A copy of the guidance is included in Attachment 5.

NEEDS ASSESSMENTS

All planning groups have discussed the needs assessment process in their regions. Due to issues around human subjects review, limitations for the gathering of certain behaviorally specific information led most planning groups to feel thwarted in attempting any population specific assessments. As a response to this issue, the DOH Assessment Unit is developing the protocols for key informant interviews, focus groups and surveys that will meet human subject review criteria. These 'tools' will be available to regional planning groups and organizations in 2002. It is anticipated that at least one assessment will be completed in each region, probably focused on the highest priority population-populations or unmet need from 2002-2003.

On a statewide basis, DOH funded two needs assessments in 2001: American Indian intervention needs and seasonal farm worker intervention needs. Neither of these assessments was available for the 2002 planning cycle, but will be completed for the 2003 cycle.

As part of the extensive prioritization process in Seattle-King County (Region 4), several needs assessment documents were reviewed. These documents included the Young Men's Study, A Public Health Perspective, the findings/report of the MSM Summit, and other nationally published materials. All of these materials were also shared with the other planning groups. (see Attachment 6 for materials and/or references)

The state planning group (SPG) received a report on the KABB (Knowledge, Attitudes, Beliefs and Behaviors) Survey and the relevant questions in the BRFSS (Behavioral Risk Factor Surveillance Survey) data (see Attachment 6 for summary information).

The state planning group (SPG), along with input from the regional planning groups, have prioritized a statewide needs assessment of young gay men of color to be conducted in 2002. Other indicated assessments will be completed on a statewide or local basis as funding and providers become available.

COMMUNITY RESOURCE INVENTORY

The SHARE (Statewide HIV Activities, Reporting and Evaluation) System is now fully operational and in its second year of data collection. All federally, state or other funded interventions, except counseling and testing and partner notification, are tracked through SHARE. A community resource inventory that lists region, agency, interventions, funding and other pertinent data can be generated as needed. This listing would provide a majority of the primary prevention activities and providers in the state. If a region chooses to list additional providers of HIV services, that inventory will be included in their local plan.

In 2001, the following organizations provided HIV prevention services in Washington: (Region in parenthesis)

Adams County Health District (1)
Asotin County Health District (1)
Benton-Franklin Health Dist (2)
Blue Mountain Heart to Heart (1)
Bremerton-Kitsap County Health Dist (5)
Chelan-Douglas Health Dist (2)
Clallam County Dept of Health & Human Services (6)
Cowlitz County Health Dept (6)
Department of Health (WA)
Evergreen AIDS Foundation (3)
Garfield County Health Dist (1)
Gay City (4)
Good Samaritan Hospital, Pierce County (5)
Grant County Health Dist (2)
Grays Harbor County Public Health and Social Services Department (6)
Home Alive (4)
International Community Health Services(4)
Island County Health Dept (3)
Jefferson County Health & Human Svcs (6)
Kittitas County Health Dept (2)
Klickitat County Health Dept (2)
Lewis County Public Health (6)
Lifelong AIDS Alliance (4) (formerly Northwest AIDS Foundation)
Lincoln County Health Dept (1)
Madison Clinic at Harborview (4)

Mason County Dept. of Health Svcs (6)
NE Tri-Counties Health Dist (1)
Okanogan County Health Dist (1)
Pacific County Health & Human Svcs (6)
Pierce County AIDS Foundation (5)
Planned Parenthood of Western WA
POCAAN – Seattle (4)
POCAAN – Tacoma (5)
Point Defiance AIDS Project (5)
Project NEON (4)
Public Health – Seattle & King County (4)
Region 1-Agency
Region 3-Agency
San Juan County Health & Community Services 3)
Sisters of Perpetual Indulgence (4)
Skagit County Dept of Health (3)
Snohomish Health Dist (3)
Spokane AIDS Network (1)
Spokane Regional Health Dist (1)
Stonewall Youth (6)
Street Outreach Services (4)
SW WA Health Dist (6)
Tacoma Urban League (5)
Tacoma-Pierce County Health Dept (5)
Thurston County Health Dept (6)
University of Washington - HAPDEU
University of Washington - Project SHAPE
Walla Walla County-City Health Dept (1)
Whatcom County Health & Human Services Dept (3)
Whitman County Health Dept (1)
Yakima Health Dist (2)
YouthCare (4)

Please refer to the next chapter of details for the 2002 planned interventions and agencies.

SUMMARY OF REGIONAL PRIORITIZATION

Each of the regions is at a different point in their prioritization process. This variability is due to:

- the different planning calendars
- decisions on what part of the process to focus on
- the size of the regional epidemic, and
- regional capacity to plan and implement interventions.

REGION 1

Region 1 is in the second year of their plan and focused on internal structure, such as recruiting community members and reviewing by-laws. Review of the populationpopulation prioritization focused on MSM and IDU behavioral risk categories. The preliminary list of prioritized populations is:

HIV+ and partners
All HIV+ individuals and their partners

MSM
Who have multiple sex partners and engage in unprotected sex
Who are also IDUs
Who are people of color
Who are youth
Who engage in unprotected sex
Who are migrant farm workers
Who are incarcerated and their spouses/partners
Who are receiving drug treatment
Who do not self-identify
IDU
Who are HIV+ and partners
Who are MSMs
Who have multiple sex partners
Who engage in unprotected sex and needle sharing
Who engage in unprotected sex (anal, vaginal, oral)
Who are high risk youth and adults
Who are people of color
Who are incarcerated and spouse/partners
Persons who are sex partners of IDUs

The rationale for ranking HIV+ and their partners number 1 for both MSM and IDU behavioral risk category was based on the literature supporting interventions, specifically early intervention and prevention case management (PCM). Data concerning increased risk of transmission with multiple sex partners, especially in public sex environments with multiple anonymous partners were reviewed. Increased cases of syphilis and gonorrhea in gay men in the Seattle area were of particular concern because of the involvement of the regional gay members and communities reporting frequent trips to the Seattle area to 'party.' STD rates in Region 1 will continue to be monitored. AIDS cases in people of color in Region 1 exceed or equal the percent of that race/ethnicity in the general population. African Americans are 1% of the population and 4% of the cumulative AIDS cases; Hispanics are 6% of the population and 5% of the AIDS cases, and American Indians are 2% of the general population and 3% of the AIDS cases. While the actual number of people is small, the increases over the epidemic are troubling. (see Attachment 4, Region 1 for further details and discussion of epidemiologic findings)

The Region 1 planning group did not prioritize the effective interventions, but adopted the SPG recommendations (Table 9). The selection of programs to meet these prioritizations was based on what was already being done, the capacity of the resources in the area and the plans that outcome monitoring will provide more concrete information about program success. Additionally, several of the programs will be evaluated over the 2002 calendar year, when implemented. For HIV+ and their partners, PCM was identified as an effective intervention and is available in Spokane and Walla Walla. The Spokane program involves a CDC directly funded program called Milestones at the Spokane AIDS Network and in Walla Walla, the capacity to provide PCM is through Blue Mountain Heart to Heart. Both are community-based organizations. Additionally, Spokane AIDS Network is directly funded by the CDC to provide a group-level intervention for MSMs called Positive Power.

Region 1 and Region 2 have entered into a joint project to adapt the L.A. Oasis Project (Dr. Wilbert Jordan) to a rural setting as an individual intervention, *Know Your Status*, Person @Risk. Dr. Jordan has consented to provide the technical assistance to this project and has secured external funding for his participation and the evaluation of this project.

A variety of interventions have been identified for people of color, specifically a reservation based peer education project called *ROPED* and migrant farm worker outreach by bilingual workers. Most of the local health departments provide jail based education and counseling and testing programs. All the local health departments provide access to high-risk counseling and testing, both confidentially and anonymously. (see Table 19 for details of the Region 1 priorities and interventions)

REGION 2

Region 2 has begun a 5-year plan (2002-2007) in which the planning process will focus each year on a behavioral risk category, starting with MSM. In 2002, the Region 2 planning group will complete the gap analysis, assessment and prioritization of interventions for MSM. The planning group has identified (but not prioritized) HIV+

MSM, MSM who under the age of 24 years and non-self-identified MSM, particularly the monolingual Spanish-speaking population. Additionally, the planning group received technical assistance (open to all workers in the state) from the Farmworkers Justice Fund on interventions to the seasonal farm worker community. Curricula for group level interventions for this population are being developed. Region 2 will also be participating, with Region 1, in the *Know Your Status* project.

Hispanics are 25% of the total population in Region 2 and account for 28% of the cumulative AIDS cases and 34% of persons living with AIDS. All counties in Region 2 have targeted bilingual programs for Hispanics, including utilization of media through the local Spanish language radio and television station.

REGION 3

Region 3 has extended their previous 3-year plan to include 2002. Region 3 has done a preliminary prioritization of populations, especially MSM and reviewed their interventions to discuss efficacy and design for targeting. The populations and interventions are listed in Table 19.

REGION 4

Region 4 developed a new plan for 2002-2003. The planning committee formed a Prioritization Subcommittee in April 2001. This committee consisted of 24 members representing the infected/affected communities, community-based organizations serving people at risk for or with HIV and public health. In over 48 hours of meetings, with 2 facilitators and numerous expert presenters, the subcommittee received information and data; met in small groups to prioritize subpopulations within the four priority populations (MSM, IDU, Heterosexual and Transgender); established the target funding levels for each of the four risk populations and prioritized the effective interventions (strategies). Much of the information and data presented at these meetings were shared with other regions, especially the Young Men's Study, the Public Health Recommendations, and the MSM STD Summit (see Attachment 6 for copies or sources of this information) Additionally, extensive review of the effective intervention literature became the basis for the state planning group effective interventions matrix and discussion at the regional level of this information (see Attachment 3). (see Table 19 for a complete list of priorities and interventions)

REGION 5

Region 5 has two separate community planning groups (CPG), Kitsap County and Pierce County. The Kitsap planning group prioritized their populations based on the epi profile. Effective interventions were prioritized based on effective intervention literature, SPG recommendations, and the community resource inventory, as follows:

	Effective Intervention
MSM	
Gay identifying	Group level intervention with social marketing and outreach components
HIV+	Prevention Case Management
Young (16-24)	Group level intervention
Non-gay identifying	Web-based intervention
MSM/IDU	
Methamphetamine users	Treatment referral, PCM, if HIV+ and referral to Project Neon
Heroin users	Needle exchange (syringe access), referral to treatment, PCM, if HIV+
IDU	
Heroin user	Needle exchange (syringe access), group level intervention, referral for treatment, PCM if HIV+
Methamphetamine user	Treatment referral, PCM, if HIV+, Needle exchange (syringe access)
Heterosexual	
Partners of HIV +	PCM, if partner of positive, Community-level intervention
Survival sex	Outreach
ALL POPULATIONS	CTR/PCRS

The Pierce County community planning group is in the second year of their 2 year planning process and affirmed the target populations established in their 2000-2002 plan. The prioritization of the behavioral risk categories ranked IDU above MSM. This decision was supported by the epi profile that identifies all three risk categories as almost evenly divided in Pierce County. Discussion of effective interventions has begun. (see Table 19 for priorities and interventions)

REGION 6

Region 6 planning group determined their behavioral risk category priorities as IDU, MSM and Heterosexual. Discussion in the planning group revolved around the epi profile that indicated that MSM is the highest risk behavior for transmission. Utilizing trend data, community resource inventory and literature supporting the increase in IDU populations convinced the planning group to rank IDU first in the priority order. The planning group discussed the population-population priorities and listed those priorities in alphabetical order, except for HIV+ person which was number 1 in all

categories. The following is a list (alphabetical) of Region 6 target populations with associated interventions:

IDU	HIV+ persons	1. Comprehensive Syringe Exchange 2. Legalization of possession and sale of syringes and other paraphernalia for disease control purposes (legislative issue) 3. Counseling and Testing 4. Group Level interventions 5. Increased access to drug and alcohol treatment (legislative issue)
	Female injectors	
	HIV+ partners	
	Homeless injectors	
	Incarcerated injectors	
	Injectors	
	MSM	
	People of color	
	Youth	
	Multiple sex partners	
MSM	HIV+ person	1. Community-level intervention in Clark, Thurston, and Skamania counties. 2. Group level interventions in rural areas. 3. Counseling and testing in all counties in the region. 4. Group level intervention for GLBT? Youth
	B/G/L/T/? youth	
	HIV+ partner	
	IDU	
	Men of color	
	Multiple sex partners	
	Non-identifying	
	Survival sex	
Heterosexual	HIV+ person	
	HIV+ partners	Counseling and testing, couples counseling
	Multiple sex partners	Counseling and testing
	People of color	Peer-led Group level int.
	Survival sex	Peer Outreach
	Women partners of IDU	Couples counseling
	Women partners of MSM	Couples counseling
	Youth	Peer-led Group level int.
OTHER	Technical assistance to increase the capacity of local public health jurisdictions and CBO's to implement effective interventions to priority populations	Region 6 AIDS Education Coordinator will provide TA and capacity building to 2 CBO's and 6 local health agencies.
	Train public and private providers of CTS (Counseling and testing) services using CDC-	Region 6 AIDS Education Coordinator will provide 4 quarterly, 2-day CTS training for 60 public and

	approved curriculum	private providers.
	Maintain an open and diverse HIV Prevention Planning Committee and produce multi-year HIV Prevention Plans and Intervention Plans	Region 6 AIDS Education Coordinator will assist Region 6 AIDS Coordinator and HIV Prevention Planning Committee to develop a Region 6 HIV Prevention Plan in accordance with National Core Objectives.

(see Table 19 for details of priorities and interventions)

WHERE

WILL

WE

GO

FROM

HERE

WHERE WILL WE GO FROM HERE

The purpose of all of this planning is to set priorities for populations to be served and methods to be used to decrease risk behaviors. Successful interventions should result in decreased transmission of HIV in the target population. This definitely has been shown to be true. The very early prevention efforts in this country were focused on gay men and injection (intravenous) drug users. In the gay community, campaigns and programs targeting gay men, safer sex, condom acceptance and community empowerment resulted in decreasing numbers of new infections. Gay men were often the driving force of and for services to their own community. In the drug using community in Washington the intervention came from both the community and public health. The founding of the Point Defiance AIDS Project in Tacoma in 1988 was a landmark event and the beginning of legal needle exchanges in the United States. This early innovative program has contributed to the stabilization of HIV prevalence rates in IDU's at less than 4% through the entire epidemic. The relative number of injectors who are alive and infected has increased, but the rates of increase of actual new cases have remained stable. This has not been true in other similar communities where needle exchanges are not available.

After 20 years of this epidemic devastating these communities and great advances in medical treatment, even the communities have lost sight of the day to day prevention activities and we are at the edge of loosing some of the previous successes. In many communities of color the issues of HIV are critical. The planning groups have taken much of this information, as well as that from epidemiology, behavioral and social sciences and health planning, and tried to set priorities for scientifically based, effective interventions to be funded in their regions.

Throughout the year the planning groups received copies of articles, cross-referenced bibliographies, reports and advise from experts on populations, interventions, and epidemic. From this information and the expertise and knowledge on the planning group, recommendations are made on what will fit best with the resources available, the target populations and the 'state-of-the-art.' Each planning group is at different stages in this process. Region 4 formed a Prioritization Committee that met for over 48 hours, heard hours of presentations, received position papers, bibliographies (annotated), analyses, and determined their priority populations and a priority list of potentially effective intervention types. The Region 5-Kitsap County Planning Group prioritized their populations and then used a logic model to determine the best intervention types. Region 3 is working through the gap analysis to clarify their target populations and identified the most important gaps, with recommendations of intervention types. Regions 1, 2 and 6 have begun the process of identifying, clarifying and prioritizing the populations and relied on the recommendations of the SPG on intervention types. As a result of this effort, the following table is a summarization of the populations, recommended intervention types for that population, the actual interventions that are associated with that population, and funding source. Each region is required to submit intervention plans that detail the interventions. All plans for federal funding were received by July 15, 2001, except those plans in Regions 3, 4, and 6 that are still in the RFP process. Intervention plans for other sources of funding are due on December 1, 2001.

Anticipated on-going 2001 plans or added 2002 plans are included wherever possible in the table. Following the table is some information on the principles of good interventions, the taxonomy (list and definition) of intervention types, and a glossary to help understand the acronyms and terms in the table.

As a reminder, the following is a copy of Table 9, the Prioritized Effective Interventions adopted by the SPG on 4/26/01:

HIV+/partners - Urban & Rural				
	HERR	HC/PI	CTR/PCRS	PCM
1	Groups Individual Level		Targeted CTR PCRS "Person @risk"	PCM
2	Community Level Intervention (Communities of color)	Social Marketing Mass Media & Other Media		
3		Hotline/Clearinghouse		

MSM - Urban and Rural			
	HERR	HC/PI	CTR/PCRS
1	Community level Interventions Group level Interventions		CTR-high risk PCRS
2	Street/Community Outreach Individual level Interventions	Social Marketing Mass Media & Other Media	
3		Hotline/Clearinghouse	

IDU - Urban and Rural			
	HERR	HC/PI	CTR/PCRS
1	Needle Exchange Community level Interventions		CTR-high risk PCRS
2	Individual level Interventions Street/Community Outreach		
3	Group level Interventions	Mass Media & Other Media Social Marketing Hotline/Clearinghouse	

HETEROSEXUAL - Urban			
	HERR	HC/PI	CTR/PCRS
1	Community level Interventions Group level Interventions Street/Community Outreach		CTR-high risk PCRS
2	Individual level Interventions	Mass Media & Other Media Social Marketing	
3		Hotline/Clearinghouse	

HETEROSEXUAL - Rural			
	HERR	HC/PI	CTR/PCRS
1	Community level Interventions Group level Interventions	Mass Media & Other Media Social Marketing	CTR- high risk PCRS
2	Individual level Interventions Street/Community Outreach		
3		Hotline/Clearinghouse	

TABLE 19

PRIORITIZED POPULATIONS AND INTERVENTIONS, ACTUAL INTERVENTIONS, AND FUNDING BY REGION.

This table summarizes the information in the regional prevention and intervention plans. While every effort has been made to include both CDC funded and state/other funded interventions, the regional plans were only required to include the CDC funded programs. This information provides an overview of the statewide efforts. (Definitions of phrases, abbreviations and acronyms in table can be found on the previous page)

MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 1	MSM – general	CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS	CLI – F2F – SAN	X	
	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	CTR/ILI - Know Your Status (Person @Risk model) GLI –Positive Power – SAN PCM – Milestone PCM – SAN	X X X	
	Youth (14-24)	GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS	GLI – OUT There - Whitman Co. GLI – Odyssey – Spokane GLI – Youth Outreach Program		
	People of Color:	Peer			
	African American	Outreach, CLI, ILI, GLI; CTR/PCRS	HC/PI – Baker Street Ministries, Faith-based	X	
	Hispanic/Latino	Outreach, ILI, CLI, GLI; CTR/PCRS	CTR/PCRS – Okanogan, Walla Walla – seasonal farm workers	X	
	Amer. Indian	Outreach, CLI, GLI, ILI; CTR/PCRS	GLI – ROPED – peer	X	
	MSM/IDU	Not specified	NEX - in selected areas		X
	Non-identifying	Not specified	Not funded		
	Incarcerated	GLI,ILI; CTR/PCRS	CTR/PCRS, HC/PI provided in several jurisdictions	X	X
	Migrant	See POC: Hispanic/Latino			
Region 2	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	CTR/ILI - Know Your Status (Person @Risk model)	X	
	Youth (<24)	GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS	Outreach – Chelan/Douglas		X
	Non-identifying	Not specified	Outreach/GLI – Yakima	X	X
	MSM/IDU	Not specified	GLI – Benton-Franklin	X	
	MSM – general	CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS	CTR/PCRS – provided by several jurisdictions	X	X
	Migrant/Spanish speakers	Outreach, ILI, CLI, GLI; CTR/PCRS	Outreach, GLI – provided by several jurisdictions. Media – Radio KDNA – Yakima	X X	X

MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 3	Multiple sex partners	GLI, CLI, Combination, CTR/PCRS	CLI - **Snohomish Friend to Friend** **	X	
			CLI – **Regional TRC Project**		X
			Outreach – **Snohomish Gay BOP**		X
			CLI – **Snohomish Gay MOP**		X
			CLI – **No. Counties F2F** – Evergreen	X	
	Rural	Not specified	Outreach – **No. Counties/EAF TRC Outreach**	X	X
			Outreach – **Snohomish TRC Project**		
			HC/PI – see San Juan HR Intervention		
	Men of Color	CLI	Outreach – see Skagit Summer Migrant		
			Outreach – see Whatcom Migrant Camp Pgm		
			GLI – RFP – Target HIV+ (POC)		
	HIV+/partners	Not specified	CLI – see Regional TRC Project		
			Outreach – see Snohomish Gay BOP		
			GLI – **RFP – Target HIV+ (POC)**	X	
	Youth	GLI	GLI – **Snohomish GLOBE**		X
			GLI – **RFP – Target Gay Youth**	X	
	MSM/IDU	Not specified	HC/PI – see Skagit IDU Project		
			Outreach – see Snohomish BOP		
			CLI – see Snohomish MOP		
	Non-identifying	Not specified	Not funded		
Region 4 ***	HIV+	PCM, GLI, Social Marketing, ILI, CLI	RFP		
	Men of Color	Outreach, GLI, CLI, CTR; (ILI, Media)****	CTR		X
			RFP		
	MSM/IDU	Needle Exchange (NEX), CLI, (ILI, Outreach, Media)	NEX		X
			CTR		X
			RFP		
	HIV-/Unknown status	CLI, GLI, Outreach, Social Marketing, ILI, (CTR)	CTR		X
			RFP		
	Youth (Street/POC)	GLI, Outreach, CLI, CTR, (ILI, Social Marketing, Media)	CTR		X
			RFP		
	MSM – general	Web Site	CTR		X
			RFP		X

MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 5-Kitsap	MSM – general (Gay identifying)	CLI, GLI, Outreach, ILI; Social Marketing, Media, CTR/PCRS	GLI, HC/PI, Web Site - OUTKitsap CTR/PCRS	X X	X X
	HIV+/partners and friends	PCM, CTR/PCRS	PCM – Bremerton-Kitsap Case Management CTR/PCRS	X X	X X
	Young MSM (16-24)	GLI	RFP	X	X
	Non-identifying	Not specified	Not funded		
Region 5-Pierce	African American	Not specified	CLI – POCAAN CTR/PCRS Outreach	 X X	X X
	Youth (14-24)	Not specified	OASIS – PCAF Youth Peer Ed Program CTR/PCRS	 X	X X X
	HIV+/partners	Not specified	Early Intervention Case Management CTR/PCRS	 X	X X
	Latino	Not specified	Outreach – see Heterosexual CTR/PCRS	X X	 X
	MSM/IDU	Not specified	NEX CTR/PCRS	 X	X X
	Sex Traders	Not specified	Not funded – see Heterosexual		
Region 6	MSM – general	CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS	CLI – Gay Life Vancouver CLI – F2F – Thurston	X X	X X
	"Rural" MSM	GLI	RFP	X	
	Multiple partners and unknown serostatus	CTR	CTR – provided in all jurisdictions	X	X
	Youth	GLI	GLI – Stonewall	X	X

** Region 3 – Bolded interventions are specifically targeted to this subpopulation. Non-bolded interventions include this subpopulation.
*** Region 4 - is in the process of accepting Referral for Proposal (RFP) applications for all prioritized subpopulations.
**** Region 4 – Recommended interventions in parentheses acceptable

IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 1	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	PCM – Milestones – SAN (see MSM) CTR/ILI - Persons @ Risk model (see MSM)		
	Needle sharing	Needle Exchange, Outreach	NEX – provided in several jurisdictions CTR/PCRS	 X	X X
	Youth (14-24)	GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS	GLI – Youth Outreach Program CTR/PCRS	 X	 X
	People of Color:				
	Hispanic/Latino	Not specified	Outreach to migrants in several jurisdictions		X
	Incarcerated	Not specified	HC/PI and CTR/PCRS provided in several jurisdictions	X	X
	Sex partners of IDU	Not specified	Not funded		
Region 2	IDU – general	Needle Exchange, Outreach, ILI, GLI, CLI, CTR/PCRS, Person @Risk model	NEX provided in several jurisdictions Outreach provided in several jurisdictions CTR/ILI - Persons @ Risk model – Yakima	 X X	 X X
Region 3	People of Color	ILI, GLI, Outreach, Combination, CTR/PCRS	See Skagit Summer Migrant (Hispanic)		
	HIV+/partners	Not specified	Outreach – **Whatcom Court Ordered CTR**		X
	MSM/IDU	Not specified	Outreach – see Snohomish High Risk (Rural) GLI – see Whatcom Dual Diagnosed (General population)		
	Female IDU	GLI	NEX– see Skagit NEX HC/PI – see Skagit IDU Project Outreach – see Snohomish High Risk GLI – see Whatcom Dual Diagnosed See Whatcom IDU Outreach		
	Youth IDU	Combination	Outreach – see Snohomish High Risk GLI – see Whatcom IDU Outreach		
	Methamphetamine	Not specified	Outreach – see Snohomish High Risk		
	Homeless IDU	Combination	HC/PI – see Skagit IDU Project Outreach – see Snohomish High Risk		

IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 3 cont.	Rural IDU	Not specified	CLI – **Island IDU Exchange** ILI – **Skagit Needle Exchange** Outreach – **Snohomish High Risk (NEX)** HC/PI – see San Juan HR Intervention GLI – see Whatcom IDU Outreach		X X X
	Incarcerated IDU	GLI	HC/PI – **Island Jail Outreach** HC/PI – **Skagit IDU Project** Outreach – **Snohomish IDU Jail** GLI – see Whatcom IDU Outreach		X X X
Region 4 ***	Homeless/Involved with legal system	Needle Exchange, Outreach, GLI, CTR, (Methadone, PCM)****	NEX CTR RFP	 X	X X X
	Women – survival sex	Needle Exchange, Outreach, CTR, (GLI, Methadone)	NEX CTR RFP	 X	X X X
	Youth <25 or new injectors <3 years	Needle Exchange, Outreach, CTR, (GLI, Methadone)	NEX CTR RFP	 X	X X X
	HIV+ or HCV+	Needle Exchange, PCM, GLI, ILI, CTR, (Methadone)	NEX CTR RFP	 X	X X X
Region 5-Kitsap	Heroin Users	Needle Exchange, (Syringe Access), Treatment referral, CTR/PCRS	NEX not funded Syringe Access program funded in place of NEX HC/PI and CTR/PCRS – Substance User Intervention	 X	 X X
	HIV+/partners	PCM, Needle Exchange, (Syringe Access), Treatment referral, CTR/PCRS	PCM Syringe Access program CTR/PCRS	X	X X
	Methamphetamine	PCM, Needle Exchange, (Syringe Access), Treatment referral, CTR/PCRS	PCM Syringe Access CTR/PCRS Referral to Project NEON	X X	X X X

IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 5-Pierce	African Americans	Not specified	NEX		X
			CTR/PCRS	X	X
	HIV+/partners	Not specified	NEX		X
			CTR/PCRS	X	X
			Early Intervention Case Management	X	X
	Homeless	Not specified	NEX		X
			CTR/PCRS	X	X
			Outreach	X	X
	IDU/MSM	Not specified	NEX		X
			CTR/PCRS	X	X
	Incarcerated	Not specified	Needle Exchange		X
			CTR/PCRS	X	X
	Latino/a	Not specified	NEX		X
			CTR/PCRS	X	X
	Youth	Not specified	NEX		X
			CTR/PCRS	X	X
			Youth Peer Education Program		X
Region 6	IDU-general	Needle Exchange, CTR, GLI, access to treatment	NEX provided in several jurisdictions		
			CTR provided in all jurisdictions	X	X

** Region 3 – Bolded interventions are specifically targeted to this subpopulation. Non-bolded interventions include this subpopulation.
*** Region 4 - In the process of accepting Referral for Proposal (RFP) applications for all prioritized subpopulations.
**** Region 4 – Recommended interventions in parentheses acceptable

Hetero-sexual	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 1	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	PCM – Milestones CTR/PCRS Persons @Risk model	X X X	X X
	(Youth) (Not listed)	Not specified	GLI – Youth Outreach Program	X	
	(Incarcerated) (Not listed)	Not specified	GLI – provided by several jurisdictions CTR/PCRS	X X	X X
Region 2	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	CTR/PCRS Persons @Risk model	X X	X
	Incarcerated	Outreach, GLI, CTR/PCRS	Outreach – provided by several jurisdictions CTR/PCRS – provided by several jurisdictions	X X	X X
	People of Color – Hispanic/Latino	ILI, GLI, Outreach, CTR/PCRS, Media	GLI – provided by several jurisdictions Media – Radio KDNA – Yakima	X X	X X
Region 3	HIV+/partners	Regional HIV investigator – CTR/PCRS	Regional HIV investigator		X
Region 4	Female partners of high risk males	GLI, ILI, Outreach (sex industry), Social Marketing, CLI, CTR	CTR RFP***	 X	X X
	People with STD's/esp. POC	GLI, ILI, CLI, CTR	CTR RFP	 X	X X
Region 5-Kitsap	Partners of HIV+	PCM, GLI, CTR/PCRS	PCM CTR/PCRS	X X	X X
	Survival sex	Outreach, CTR	Outreach/CTR/PCRS	X	X
Region 5-Pierce	African American Women	Not specified	Outreach – Good Samaritan – Latinas CLI – Women of Color, Incarcerated Youth – TUL	X X	
Region 6	HR/unknown status	CTR/PCRS	CTR/PCRS – all jurisdictions provide CTR	X	X
	Survival sex	Peer Outreach	Not funded		
	Female partners of MSM or IDU	PCM	PCM		X
	HIV+/partners	PCM, couples counseling	PCM Couples counseling		X X
	People of Color	Peer GLI	Not funded		
	Youth	Peer GLI	Not funded		

*** Region 4 is in the process of accepting Referral for Proposal (RFP) applications for all prioritized subpopulations

Other	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 3	Hispanic	Not specified	Outreach – **Skagit Summer Migrant** CLI – Snohomish POC HC/PI – Whatcom Hispanic & Migrant		X
	General Population – risk unknown	Not specified	HC/PI - **San Juan Prevention & Education** HC/PI - **San Juan HR Intervention** HC/PI - **Skagit General Education** GLI - **Snohomish Drug Treatment** HC/PI - **Snohomish HIV Pre/Post Test Trng** GLI - **Snohomish Speakers Bureau** CLI - **Snohomish Train the Trainer** CLI - **Whatcom Community Health** GLI – **Whatcom Dual Diagnosed** HC/PI - **Whatcom IDU Outreach**		X X X X X X X X X X
Region 4	Transgender	To be determined by Needs Assessment	RFP – Needs Assessment RFP – Intervention	X X	X X

Intervention Principles

These intervention principles are indicators which have been shown to be included in effective interventions and should be a standard of practice when selecting, developing and implementing an HIV intervention.

Intervention

- Clearly defined audience
- Clearly defined goals and objectives
- Behavioral/social science theory
- Accurate information about HIV risk behaviors
- Focus on reducing specific risk behaviors
- Opportunities to practice relevant skills

Implementation

- Realistic schedule
- Key elements
- Sensitivity to target population
- Trained staff
- Variety of teaching methods
- Information personalized
- Essential HIV messages repeated

Organization

- Administrative support
- Sufficient resources
- Program sustainability
- Decision markers are flexible
- Broader context relevant to target population

Consumer/Participant

- Intervention meets priorities and needs defined by community
- Audience included in ongoing tailoring
- Intervention as implemented is:
  - culturally competent
  - developmentally appropriate
  - gender specific
- Intervention as implemented is acceptable to participants

- All activities also need to be consistent with Federal and State laws.

Centers for Disease Control and Prevention, Presented at the 1998 HIV/STD Educator/Trainer Meeting. Atlanta, Georgia. November 17, 1998

TABLE 20 - INTERVENTION TYPES

INTERVENTION	INCLUDES	EXCLUDES
A. Individual Level Intervention (ILI)	Health education and risk reduction intervention provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.	Excludes outreach or prevention case management. Each constitute their own intervention category.
B. Group Level Intervention (GLI)	Health education and risk reduction intervention (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support (DOH has added the requirement that the GLI must be multiple sessions).	Excludes group education that lacks a skills component and or is a single session. Those types of activities should be included in the Health Communication/Public Information category.
C. Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients' typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials.	Excludes condom or material drop offs and other outreach activities that lack face-to-face contact with a client.
D. Prevention Case Management (PCM)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.	Excludes one-to-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage.
E. Partner Counseling and Referral Services (PCRS)	A systematic approach to notify sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.	Excludes HIV counseling and testing which is reported in its own category using the standard bubble sheets.
F. Health Communication/ Public Information (HC/PI)	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. **Electronic Media**: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcast, infomercials, etc., which reach a large-scale (e.g., city, region, or statewide) audience. **Print Media:** These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.	Excludes group interventions with a skills building component, which constitutes its own intervention category.

INTERVENTION	INCLUDES	EXCLUDES
	Hotline: Telephone service (local or toll free) offering up-to-date information and referral to local services, e.g., counseling/testing and support services **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide responsive information service to the general public as well as high-risk populations. **Presentations/Lectures:** These are information-only activities conducted in-group settings; often called "one-shot" education interventions. **Social Marketing:** Uses techniques adapted from commercial marketing to identify specific audiences called segments and their perceived needs, and then constructs a program of services, support, and communication to meet those needs.	
G. Counseling, Testing and Referral (CTR)	An individualized intervention of usually two session (pre-test and post-test) aimed at learning current serostatus; increasing understanding of HIV infection; assessing risk of HIV acquisition and transmission; negotiating behavior change to reduce risk of acquiring or transmitting HIV; and, providing referrals for additional medical, preventive and psychosocial needs. HIV counseling and testing is more than an information session; however, it is not therapy. This intervention is closely linked to Partner Counseling and Referral Services (PCRS)	Excludes PCRS which is reported in its own category using the standard reporting forms.
Other Interventions	Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other seven types of interventions (example forms A-G). This category included community level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization, social marketing campaigns, community-wide events, policy interventions, and structural interventions.	Excludes any intervention that can be described by one of the existing categories.

GLOSSARY FOR PRIORITIZED POPULATIONS AND INTERVENTIONS TABLE.

The following abbreviations, acronyms and terms are defined in the explanation of intervention types **CLI, CTR, GLI, HC/PI, ILI, MEDIA, OUTREACH, PCM, PCRS, AND SOCIAL MARKETING.**

Access to Tx – development of collaborations, agreements and other means to enhance or assure access to substance abuse treatment.

BOP – Bar Outreach Program. Outreach program in Snohomish county (Region 3) to MSM in bars.

Combination – Interventions that are characterized by combinations of intervention types, but not resulting in a community-level intervention.

EAF – Evergreen AIDS Foundation. AIDS service organization (ASO) in Bellingham, Region 3.

Early Intervention Case Management – Case management related prevention intervention for HIV+ in Pierce county, Region 5.

F2F – Friend to Friend. A community level intervention for MSM based on the popular opinion leader model of Jeff Kelly, et al.

GLOBE – Gay, Lesbian, Open-minded. Bisexual Empowerment. A youth empowerment program in Snohomish County, Region 3.

HCV+ - a person who has been diagnosed with Hepatitis C.

HIV- - A person who has been diagnosed as not being HIV infected through a negative HIV-antibody test.

HIV+ - a person who has been diagnosed with HIV disease through a positive HIV antibody test.

HR – high risk. Anyone who is practicing behaviors that put them at risk for HIV transmission.

IDU – Injection drug user. A person who is practicing behaviors that include injecting legal and illegal substances intravenously, intramuscularly and subcutaneously.

MOP – Men's Outreach Project. An outreach program to gay men in Snohomish County, Reg. 3.

MSM – Men who have sex with men. A person who are sexually involved with other men, even if they do not identify with being termed gay or bisexual.

MSM/IDU – a person who practices behaviors as both an MSM and IDU that put them at risk for HIV transmission. Interventions targeted to this group must address both sets of behaviors equally.

NEX – Needle (Syringe) Exchange. An intervention that provides sterile injection equipment in exchange for used equipment.

Not specified – an effective intervention recommendation either not identified or included in the regional HIV prevention plan.

PCAF – Pierce County AIDS Foundation. ASO in Pierce County, Region 5.

Peer – an intervention that is delivered by a member of the target population.

Person @Risk model – a pilot project in Regions 1 and 2 to explore the use of a CTR/PCRS intervention develop by Dr. W. Jordan at Oasis Clinic in Los Angeles.

POC – people of color.

POCAAN – People of Color Against AIDS Network. A Seattle ASO that provides services to communities of color in Regions 2, 4 and 5.

Project Neon – A program in Region 4 specifically targeting Methamphetamine MSM.

Radio KDNA – a local radio and TV station in Region 3 serving the Spanish speaking communities in Yakima and surrounding communities.

RFP – Request for Proposal or Program. A process by which a contractor calls for bids to provide a specific intervention. A process utilized in all regions. A listing of RFP in the table indicates that the RFP process has been identified, but the contractor has not yet been selected. For updated information on these interventions, contact the regional coordinator or DOH.

ROPED – Reservation Outreach and Peer Education Development. An intervention in Region 1 targeting American Indians on tribal land.

SAN – Spokane AIDS Network. An ASO in Spokane, Region 1.

STD – sexually transmitted disease

TRC – Triangle Recreation Camp. A gay men's annual summer gathering in Snohomish county, Region 3.

TUL – Tacoma Urban League. A community-based organization (CBO) in Pierce county, Region , serving African Americans and other communities of color.

Unknown serostatus – a person who practices behaviors that might put them at risk for HIV transmission, but has not tested for HIV antibodies or has not revealed any test results.

NEEDS ASSESSMENTS

Throughout 2002-2003, each region will be conducting target population needs assessments that are appropriate to complete the gap analysis and planning. The data from these assessments will determine what changes will be made in the priority populations and interventions. DOH is developing tools and procedures that can be used to do these assessments in a systematic and appropriate way.

On a statewide basis, the set-aside priorities have identified an assessment of young gay men of color. There will also be a follow-up on the American Indian assessment, with consultation and technical assistance from national experts. The findings of the seasonal farm worker needs assessment will determine the priority interventions throughout the state.

OUTCOME MONITORING

By the end of 2001, the project to identify and develop methodologies and tools for outcome monitoring of health education and risk reduction (HERR) individual and group level interventions will be completed. With these tools, the intervention providers will be able to begin monitoring the actual outcomes of their intervention efforts. Monitoring of counseling/testing, partner counseling and referral services and prevention case management interventions already have quality assurance and outcome monitoring methods established.

OUTCOME EVALUATION

The multi-year project to evaluate the Friend to Friend Project will be in its third year. A great deal of information has already been summarized about MSM behavior, needs and activities. This information will be available to the planning groups for their next cycle of planning.

The prevention case management program at Harborview and Lifelong AIDS Alliance has been undergoing a program evaluation by PHSKC through a CDC funded process. This evaluation should be completed in December of 2001 and will be available to the regions for consideration in utilizing PCM interventions.

SPECIAL PROJECTS

KNOW YOUR STATUS (PERSON @RISK Model)

With Dr. Wilbert Jordan as consultant and an outside evaluator, the prevention and care providers identified in Regions 1 and 2 will design, implement and outcome monitor an adaptation of the L.A. Oasis Clinic model for rural, individual interventions with high-risk individuals. (*Journal of the National Medical Association* 1998; Vol. 90, No. 9, pages 542-546). The intervention design utilizes incentives to identified HIV+ people to facilitate identification of people they think are at risk for HIV infection. The people

identified are then asked to participate in an incentive educational program that provides the opportunity for HIV antibody testing. The results of this intervention (as a group process) resulted in increased identification of HIV+ people in hard to reach communities.

SEASONAL FARM WORKER COORDINATION PROJECT

As part of the needs assessment of seasonal farm workers in Washington, the migratory patterns will be explored. From this information, a network of the outreach workers across the state will meet to discuss and design a coordination process for HIV education and outreach to seasonal farm workers. The outcome of this project should be increased numbers of seasonal farm workers who self-identify as high-risk and, concurrently, an increase in the number of those individual who know their status and have received risk reduction information.

WHAT

STILL

NEEDS

TO BE

DONE

WHAT STILL NEEDS TO BE DONE

In the planning process and under CDC guidance, each jurisdiction is required to identify the unmet needs of their state or community. As with all decisions, unmet HIV prevention needs in the state of Washington are the result of – or impacted by – several factors or barriers, including legislation and policy, knowledge (assessment and technology), and resource limitations (funding, staffing and service capacity). Each of these factors contribute to unmet needs. For example, statewide local policies and laws create barriers to access to new sterile syringes/needles for IDU's, whether through pharmacies or needle exchange programs. Lack of data (especially prevalence and incidence data) contributes to a situation in which the cost-effectiveness of many programs and approaches can be speculated. "Hard-to-reach" subpopulations (i.e. HIV infected persons who do not know their serostatus, or men who do not identify their sexual activity with other men as significant or relevant to their risk for HIV transmission) remain difficult to plan for and reach. Resource constraints limit the ability of the department to fund community partners to deliver prevention services or build capacity, especially in rural areas. Staffing limitations at DOH hampers the availability of technical assistance, evaluation and quality assurance.

For most priority populations and interventions, funding limits create unmet needs that are primarily "level of effort" rather than a complete absence of a program or services. As an example, all populations have access to counseling and testing services, but the ability of small health departments to provide specifically targeted services for very small populations is difficult to balance with all of the other demands on that health department. It is very difficult to fund multiple effective interventions to all identified populations, so often one or two programs are funded in hopes of 'catching' the most at-risk people. As a result, all of the populations identified in this plan have unmet needs. In particular, prevention programs for the following subpopulations on a statewide basis have the greatest level of unmet needs. Exclusion or inclusion on this list does not mean that all of the needs are met or that there is no effort to reach this population.

Population/Subpopulation	Unmet Needs	Barriers/Constraints
HIV-infected persons	Individual, group and community level interventions to establish and maintain safer sex practices	Funding; access and recruitment
Injection Drug Users	1. Substance Abuse Treatment 2. Access to sterile needles/syringes	1. Funding and preferential admission to more programs 2. Law and policy
Female partners of MSM, IDU or person with HIV	Knowledge of at-risk status	1. Effective strategies that identify these at-risk women. 2. Cost effective interventions

African Americans at-risk	1. Knowledge of at-risk status 2. Community level interventions	Funding; social/cultural barriers resulting from disenfranchisement and health disparities.
American Indians at-risk	Lack of identified effective interventions	Funding; multiple sovereign nation status; culturally appropriate interventions.
MSM with multiple anonymous partners, especially in public sex environments	Group and Community level interventions	Funding; resistance due to community norms and values
Non self-identifying MSM	Acknowledgement of risk behaviors and interventions to identify and promote safer sex practices	Effective interventions research, cultural and language barriers, social norms and values.
Rural populations at-risk	1. Knowledge of at-risk status 2. Identified effective rural interventions	Cost effective, scientifically proven interventions for rural settings; community norms and values.

Even with identification of these unmet needs on a statewide basis, the ability to meet these needs continues to be limited by lack of identified effective interventions, lack of resources to evaluate presently funded programs, and resistance in communities and decision making bodies to implement changes necessary to impact the barriers.

The development of a gap analysis model and guidance may impact some of these issues on a statewide basis. It will have more of an impact on local planning and prevention efforts.

TECHNICAL ASSISTANCE

Regions were asked to identify their technical assistance needs for the next 2 years. These technical assistance needs often reflect the unmet HIV prevention needs or frustrations in the region. The statewide goal of providing technical assistance, training, and consultation with each region is the overall response to these needs. Technical assistance may be provided by the region, DOH or national TA providers, depending on the level and extent of the need and resources.

REGION	Identified TA Needs
1	Community Resource Inventory development Cost Effectiveness determination Program Evaluation Rural Interventions Prioritization of subpopulations
2	Evaluation/outcome monitoring of 'behavior change' Small group interventions

	Program evaluation for 'ongoing' interventions in rural areas Effective rural interventions Gap analysis and cost effectiveness
3	Application of needs assessment data, gap analysis and community resource inventory to prioritization process. Effective interventions
4	No technical assistance identified in plan
5-Kitsap	Evaluation and outcome monitoring Effective interventions for rural settings
5-Pierce	Prioritizing special populations Interpretation of epidemiologic data Parity, inclusion and representation Evaluation of the planning process Evaluating HIV prevention strategies Cost analysis Gap analysis Group dynamics/conducting effective meetings Team work
6	Cost effectiveness Cultural barriers in HIV Prevention Effective interventions and prevention technology, especially for rural settings.

COMMUNITY PLANNING

Improving the community planning process in all planning groups is a universal goal. Each planning group conducts process evaluations of their planning procedures and products and modifies their by-laws, procedures, and policies as needed. Review of the process evaluations included in regional plans reflects a positive process. Where issues were raised, minutes reflect resolution or, at least, discussion. All planning groups are torn between 'takes too much time' and 'there is never enough time to do everything we need to do.' Perhaps the best measure of the success, or stubbornness, of the community planning process is the longevity of service demonstrated on and by the groups. Over 50% of those involved in planning have been listed on at least 3 years of membership lists and over 75% have served for more than 2 years. All of the planning groups provide orientation and support of their members and this process has been appreciated by members. All of the members indicated, at some point, that the process can be overwhelming when you are new or the issues become very complex. Community planning has become progressively more complex over the years and this has contributed to rising levels of frustration with the process. But, people 'hang in there' and get through it to participate.

Washington State has participated, for the past 2 years, in the national workgroup to develop a Community Planning Evaluation. This workgroup has completed its initial process and the pilot evaluations began in 2001. Washington State will be one of the participants of the pilot evaluation.

LETTERS OF CONCURRENCE

Each planning group reviewed their regional/ state plan and the application for CDC funding. After this review, each planning group determined that the allocations for their region reflected the priorities established in their plan. The letters of concurrence of this process are contained in this section.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

September 7, 2001

Centers for Disease Control and Prevention
Grants Management Branch, Procurement and Grants Office
Ron Van Duyne, Grants Management Officer
Annie Harrison Comacho, Grants Management Specialist
Program Announcement 99004
2920 Brandywine Rd., Room 3000, Mail Stop E-15
Atlanta, Georgia 30341-4146

RE: Cooperative Agreement
Washington State HIV Prevention Project

Dear Ms. Comacho:

As described in the narrative of the 2002 Cooperative Agreement Application, responsibility for assessing and concurring on funding for statewide, identified unmet HIV prevention needs resides with the Washington State HIV Prevention Community Planning Group (SPG). The SPG fulfilled its responsibility after careful review of the 2002-2003 HIV Prevention Plan and Application.

Members of the SPG reviewed the 2002-2003 HIV Prevention Plan and the 2002 Application at the August 23, 2001 meeting of the SPG. Members were asked to specifically review the Application to determine the extent to which it reflected the prioritized unmet needs and recommended interventions in the Plan.

Members of the SPG were actively involved in all levels of determining the unmet HIV prevention needs for 2002. More than 2/3's of the members participated in at least one SPG committee that identified or reviewed at-risk populations, effective strategies, unmet prevention needs and regional plans. Additionally, 2/3 of the SPG membership are representatives of their respective Regional Planning Groups (RPG). This year's plan was a compilation of the 6 regional plans.

At the August 23, 2001 meeting of the SPG, members unanimously determined, through consensus, that the 2002 Washington State HIV Prevention Project Application is responsive to the program priorities identified in the comprehensive HIV Prevention Plan for Washington State. The concurrence with the application was without reservation.

Copies of concurrence letters from the regional planning groups (RPG) to the SPG are included in the application.

If there are any questions, please contact John F. Peppert at (360) 236-3427 or by email at john.peppert@doh.wa.gov

Sincerely,

Jack Jourden
Health Department Co-Chair

Pamala Sacks
Community Co-Chair

Enclosure

cc: Nikki Economou

SPOKANE REGIONAL HEALTH DISTRICT

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

September 7, 2001

Dear Jack:

Please be advised that the Region 1 Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Center for Disease Control and Prevention (CDC, federal) and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region 1 2002 HIV Prevention Plan. Eleven voting members concurred, one submitted a letter of exception, and three chose not to vote. The member who submitted the letter of exception stated that while funding did target prioritized populations, a greater proportion of funding should have focused on IDUs.

Sincerely,

Steve R. Dennuller
for Muril Demory
Community Co-chair

Barry L Hitt
Barry Hitt
Health District Co-chair

1101 W COLLEGE AVE • SPOKANE, WA 99201-2095 • (509) 324-1500 TDD (509) 324-1464

Yakima Health District
104 North First Street
Yakima, Washington 98901
Phone (509) 575-4040
Fax (509) 575-7894

July 5, 2001

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region II Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region II 2002 HIV Prevention Plan.

Sincerely,

Deborah Severtson-Coffin

Community Co-chair
Deborah Severtson-Coffin

W. J. Doescher

Health Dept. Co-chair
Wendy Doescher, Region II
AIDSNET Coordinator

SNOHOMISH HEALTH DISTRICT

REGION 3 AIDS SERVICE NETWORK
3020 Rucker Avenue, Suite 300
Everett, WA 98201-3900
(425) 339-5211 FAX: (425) 339-5216
Hearing Impaired: (425) 339-5252

Healthy Lifestyles, Healthy Communities

September 10, 2001

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region 3 HIV/AIDS Community Planning Group met on Wednesday, September 5, 2001 and reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region 3 2001-2002 HIV Prevention Plan.

Sincerely,

Stephen Dorn
Community Co-chair

M. Ward Hinds, MD, MPH
Public Health Co-chair

SD/MWH:apw

LetterOfConcurrence_091001

APPENDIX III

SEATTLE HIV/AIDS PLANNING COUNCIL

C/O PUBLIC HEALTH – SEATTLE & KING COUNTY
400 YESLER WAY, THIRD FLOOR, SEATTLE, WASHINGTON 98104
PHONE (206) 296-4527 FAX (206) 205-5281

July 10, 2001

Jack Jourden, Director
Infectious Disease and Reproductive Health Section
Washington State Department of Health
P.O. Box 47844
Olympia, Washington 98504-7844

Dear Jack:

The Seattle HIV/AIDS Planning Council is the community planning body charged with determining the priorities which dictate the expenditure of certain local, state and federal HIV/AIDS care and prevention services funds granted to Public Health – Seattle & King County (PHSKC). The Council serves as the Region IV Prevention Planning Group.

The Council has reviewed the proposed allocation of funds for HIV prevention services in the Region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target prioritized populations and support effective interventions, as outlined in the Region IV 2002 HIV Prevention Plan.

Please contact Jim Jorgenson, Planning Council Coordinator (206-205-5511) should you have any questions about this correspondence.

Sincerely,

Sam Soriano

Sam Soriano, Community Co-chair
Prevention Planning

Bob Wood

Bob Wood, M.D., Public Health Co-chair
Prevention Planning

Bremerton ❖
Kitsap County
Health District

Willa A. Fisher, MD, MPH, Director
109 Austin Drive
Bremerton, WA 98312
(360) 337-5235
FAX (360) 337-5298

June 14, 2001

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region V Kitsap County HIV Prevention Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the county. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region V Kitsap County 2002 HIV Prevention Plan.

Sincerely,

John Abrams
Community Co-chair

Lenore Morrey
Health District Co-chair

Cc: Region V AIDSNet Coordinator

Pierce County HIV Prevention Community Planning Group

September 6, 2001

Jack Jourden, Health Department Co-Chair
P.O.Box 47840
Olympia, WA 90504-7840

REF: Letter of Concurrence

Dear Jack Jourden:

The Pierce County HIV Prevention Community Planning Group met August 20, 2001, to review the 2002 budget and priorities of Pierce County.

We voted unanimously that the budget proposal allocation reflects HIV prevention priorities of our community. Therefore **we, the Pierce County HIV Prevention Community Planning Group supports a full letter of concurrence.**

The Ellensburg Document outlines the role of the Community Planning Group concerning CDC and Omnibus dollars. A letter of concurrence indicates the proposed budget or plan addresses the populations outlined in the HIV Prevention Plan.

Sincerely,

Howard Russell
Community Co-Chair
Pierce County

Mary Saffold
Health Department Co-Chair
Pierce County

Region VI **AIDS Services Network**
120 East Union Avenue #220
Olympia, Washington 98501

(360) 664-0796

Fax 664-3576
Education Coordinator 664-0798

May 21, 2001

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region 6 HIV Prevention Planning Committee has reviewed the proposed allocation of CDC funds for HIV prevention services in the region for CY 2002. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention funding to target the prioritized populations with effective interventions, as outlined in the Region 6 2002-2004 HIV Prevention Plan. When the committee has reviewed the intervention plans for state AIDS Omnibus funds, we will issue a letter of concurrence or non-concurrence as appropriate at that time.

Sincerely,

Clain Lust
Community Co-chair

Brown McDonald
Health Department Co-chair

THE FOLLOWING IS A LIST OF ATTACHMENTS AVAILABLE FOR THIS PLAN:

ATTACHMENT 1: Ellensburg Document
ATTACHMENT 2: Effective Intervention Matrix
ATTACHMENT 3: Regional Epi Profiles
ATTACHMENT 4: Gap Analysis Guidance
ATTACHMENT 5: Assessment Documents
ATTACHMENT 6: Acronyms and Glossary
ATTACHMENT 7: Little Blue Book

These attachments consist of a total of 316 pages and are available, upon request, in an electronic form.

If you wish to order the disk of these documents, please call, write or email:

Nancy Hall, HIV Planner
Washington State Department of Health
HIV Prevention and Education Services
P.O. Box 47840
Olympia, WA 98504-7840
(360) 236-3421 (Desk)
(360) 236-3400 (FAX)
nancy.hall@doh.wa.gov

There is no charge for the disk and the information may also be available on our website at: www.doh.wa.gov/cfh/hiv.htm